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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00195									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			d. STREET ADDRESS 750 West North Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Philip Julian Akers					4. DATE OF DEATH Month Day Year January 24 19 62				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 12, 1904		9. AGE (In years; last birthday) 57 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) paper hanger				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Akers					14. MOTHER'S MAIDEN NAME Rose McAbee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown					16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Alcoholism with Delirium Tremens.								INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>George M. Kieffer</i>		EXAMINER'S NAME (Type) George M. Kieffer, M. D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-24-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-27-62		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or country) (State) Woodlawn, Maryland		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	
23. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, Zone 2				24a. REC'D BY REGISTRAR JAN 29 '62					

NO 195



Officially Registered Patent Medicine

Guaranteed Absolute Purity and Efficiency

11-11-11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00196

00199

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle H. Last Alder		4. DATE OF DEATH Month Jan. Day 29 Year 1962.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 22, 1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Alder		14. MOTHER'S MAIDEN NAME Anne Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-05-0899	
17. INFORMANT Newton M. Alder		Address 5101 Brookgreen Rd. (29)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chs. Hypertensive Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1043X		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 10 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 25, 1962 , to Jan. 29, 1962 , that I last saw the deceased alive on Jan. 29, 1962 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		ADDRESS (Street, city or town, state) DATE SIGNED 1-30-62	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		Baltimore - 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-1962	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Howard Strong		24a. REC'D BY REGISTRAR DATE JAN 31 '62	
ADDRESS 3207 W. North Ave.		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASS. REG. STATE DEPT. OF HEALTH - BOSTON, 18

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00200

00152

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE New Jersey	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		b. COUNTY Palmyra	
c. LENGTH OF STAY IN 1b 172 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 307 West Third Street	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS BERNARD ALLEN		4. DATE OF DEATH Month Day Year January 19 1962	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1915
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Riverton, New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Allen		14. MOTHER'S MAIDEN NAME Phoebe Scott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-11		16. SOCIAL SECURITY NO. 149-01-5156	
17. INFORMANT Clin Rec VAH Baltimore Md - Ft Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX 161x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TUBERCULOSIS, PULMONARY MODERATELY ADVANCED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 31 1961 to Jan. 19 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 19, 1962 , and that death occurred at 8:10 p.m. from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert M.D.		22b. DATE SIGNED 1-20-62	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.		22d. ADDRESS VAH, Balto. 18 Md., Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Berkley National Cemetery		23d. LOCATION (City, town or county) (State) Berkley, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE Charles G. ... Lunsil Funeral Home		25a. REC'D BY REGISTRAR JAN 23 '62	
25b. REGISTRAR'S SIGNATURE ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00199

00202

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7448 Edsworth Road		d. STREET ADDRESS 7448 Edsworth Road #22	
3. NAME OF DECEASED (Type or print) First UDA Middle G. Last ANDERSON		4. DATE OF DEATH Month Jan. Day 9 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/85
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Delta Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William J. Bennington		14. MOTHER'S MAIDEN NAME Margaret Bullett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mildred Antis, dght. above	
17. INFORMANT Mildred Antis, dght. above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the uterine & bladder DUE TO with generalized metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia & secondary anemia DUE TO Generalized arteriosclerosis (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Aug 1961 Jan 3-1962	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-3 19 62 to 1-9 19 62 , that I last saw the deceased alive on 1-9 19 62 , and that death occurred at 9:30 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7448 Edsworth Road Dundalk Md DATE SIGNED 1/13/62	
ACTUAL SIGNATURE Eugene F. New M.D.		DATE SIGNED 1/13/62	
PHYSICIAN'S NAME (Type) Eugene F. New M.D.		DATE SIGNED 1/13/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek ADDRESS 3331 Brehms Lane		24a. REC'D BY REGISTRAR 1/15/62 24b. REGISTRAR'S SIGNATURE 1/15/62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text, possibly "John Smith"]</p>		<p>AGE [Faint text, possibly "45"]</p>	
<p>SEX [Faint text, possibly "Male"]</p>		<p>RACE [Faint text, possibly "White"]</p>	
<p>DATE OF BIRTH [Faint text, possibly "Jan 15, 1875"]</p>		<p>DATE OF DEATH [Faint text, possibly "Jan 20, 1920"]</p>	
<p>PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]</p>		<p>PLACE OF DEATH [Faint text, possibly "Boston, Mass."]</p>	
<p>CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>		<p>IMMEDIATE CAUSE [Faint text, possibly "Myocardial Infarction"]</p>	
<p>PERMANENT CAUSE [Faint text, possibly "Atherosclerosis"]</p>		<p>INTERESTING FACTS [Faint text, possibly "No previous illness"]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]</p>		<p>SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]</p>	
<p>DATE [Faint text, possibly "Jan 20, 1920"]</p>		<p>PLACE [Faint text, possibly "Boston, Mass."]</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH-DEATH-18

THIS CERTIFICATE IS TO BE FILED IN THE BIRTH-DEATH RECORDS OF THE STATE OF MASSACHUSETTS.

RECEIVED JAN 21 1920

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

<div>1</div> <div>after</div> <div>the funeral</div> <div>Pages 1 and 2 should</div> <div>be filed within 72 hours after death</div>																	
<div>00201</div> <div>CERTIFICATE OF DEATH</div> <div>00198</div>																	
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN lb <u>7 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3001-4</u> d. STREET ADDRESS <u>3113 Woodland Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>CORNELIUS</u> Middle <u>J.</u> Last <u>ANGLAND</u>						4. DATE OF DEATH Month <u>JANUARY</u> Day <u>26</u> Year <u>19 62</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 21, 1889</u>		9. AGE (In years last birthday) <u>72</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Morris Angland</u>						14. MOTHER'S MAIDEN NAME <u>Ellen Callahan</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> <u>WW I</u>						16. SOCIAL SECURITY NO. <u>216-01-5392</u> 17. INFORMANT <u>Clinical Records, VA Hospital, 3900 Loch Raven Blvd. Ft. Howard Division</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>491X</u> <u>24532</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PARKINSONISM</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> <u>Unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease, Chronic Brain Syndrome, secondary to / Cerebral Arteriosclerosis</u>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that <u>He</u> (this hospital) attended the deceased from <u>January 19, 1962</u> , to <u>January 26, 1962</u> , that <u>he</u> (we) last saw the deceased alive on <u>January 26, 1962</u> , and that death occurred <u>6:40 PM</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Antonio Bulls, M.D.</u>						22b. DATE SIGNED <u>1/27/62</u>											
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO BULLS, M.D.</u>						22d. ADDRESS <u>VAH, BALTO. MD. FT HOWARD DIVISION</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1/30/62</u>			23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Baltimore</u> <u>Maryland</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>Vernon Lemon</u>						25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JAN 29 '62</u> <u>Arthur S. Klaus</u>											
25. VERNON LEMON Funeral Home, 1611 Park Hts. Ave. Balto 15, Md.																	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00203

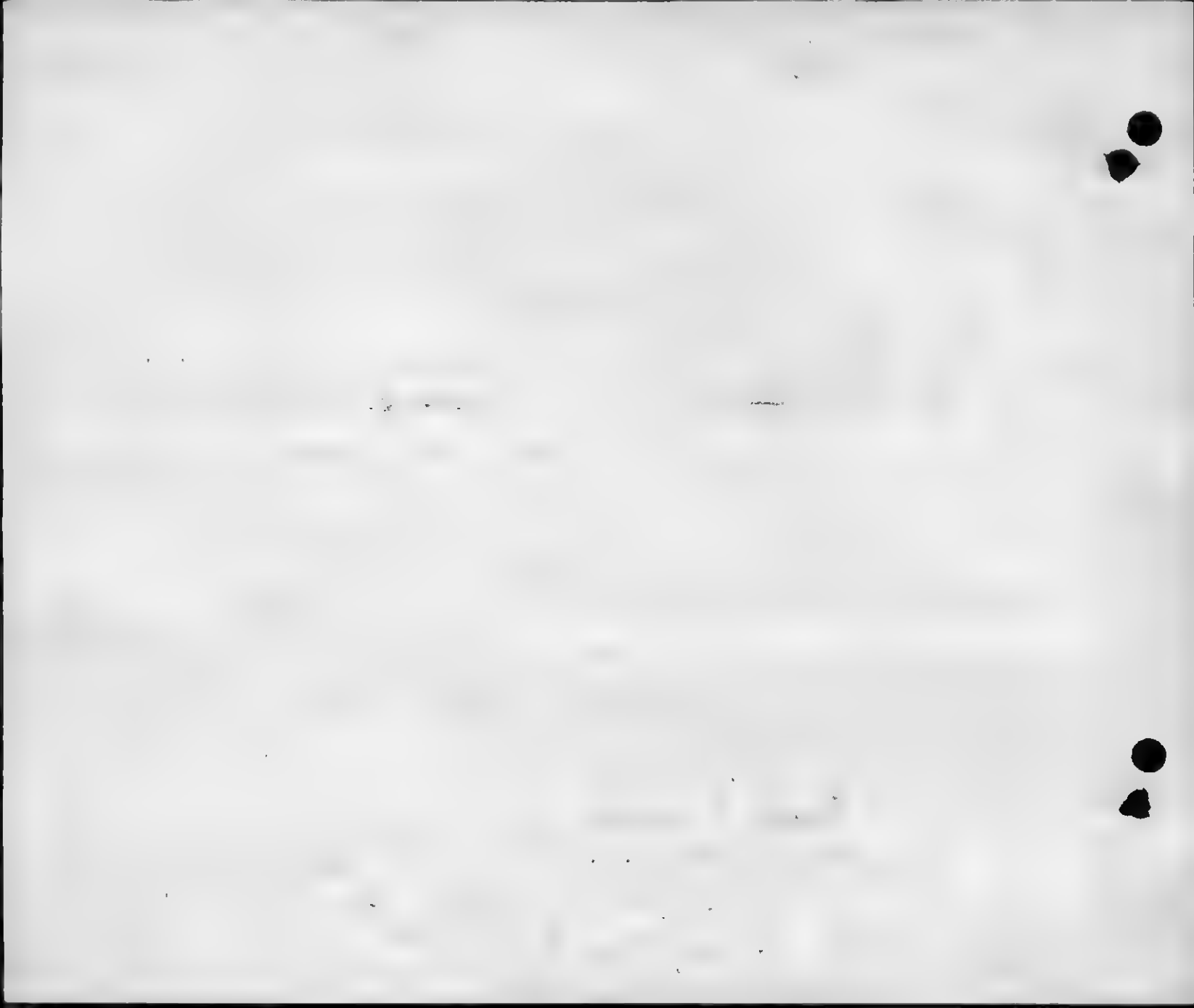
CERTIFICATE OF DEATH

00200

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY (In days) 46yr7mth23dys			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS Bayview Hospital			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Arnold				4. DATE OF DEATH Month Day Year January 15 1962			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year 1889	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days 72		11. IF UNDER 24 HRS. Hours Min. 72		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tobacco blender				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (County & State, or foreign country) U. S.				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Joseph Arnold				14. MOTHER'S MAIDEN NAME Marie Hilgefort			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unk own			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from... May 22 7:40 15 to... Jan. 15 ..., 19... 62 that (I) (we) last saw the deceased alive on... Jan. 15 ..., 19... 62 , and that death occurred at... 7:40 M., from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler M.D.				22b. DATE SIGNED 1-15-62			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-1962		23c. NAME OF CEMETERY OR CREMATORY Wesley Meth		23d. LOCATION (City, town or county) (State) Catonsville Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wesley Meth				25a. REC'D BY REGISTRAR 0 62			
25b. REGISTRAR'S SIGNATURE Clinton L. Thomas							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00204

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 111211

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essey</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>102 N. Stuart St. Balto. 21</u>				d. STREET ADDRESS <u>102 N. Stuart St. (21)</u>			
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>MAY</u> Last <u>Bader</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>24</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Shaw</u>				14. MOTHER'S MAIDEN NAME <u>Agnes De Jay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Husband (Same as above)</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ct of Ovary</u> <u>175.0</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>16 Months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C. Collins</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-24-62</u>			
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-27-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Morland's Mem.</u>		22d. LOCATION (City, town, or county) <u>Balto.</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly 418 Eastern Blvd.</u>				24a. REC'D BY REGISTRAR <u>JAN 29 1962</u>		24b. REGISTRAR'S SIGNATURE <u>J. S. Hanna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be signed by the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. Forwarded to the Medical Examiner's Office along with form PM3. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film G-105 1/16/62 mh

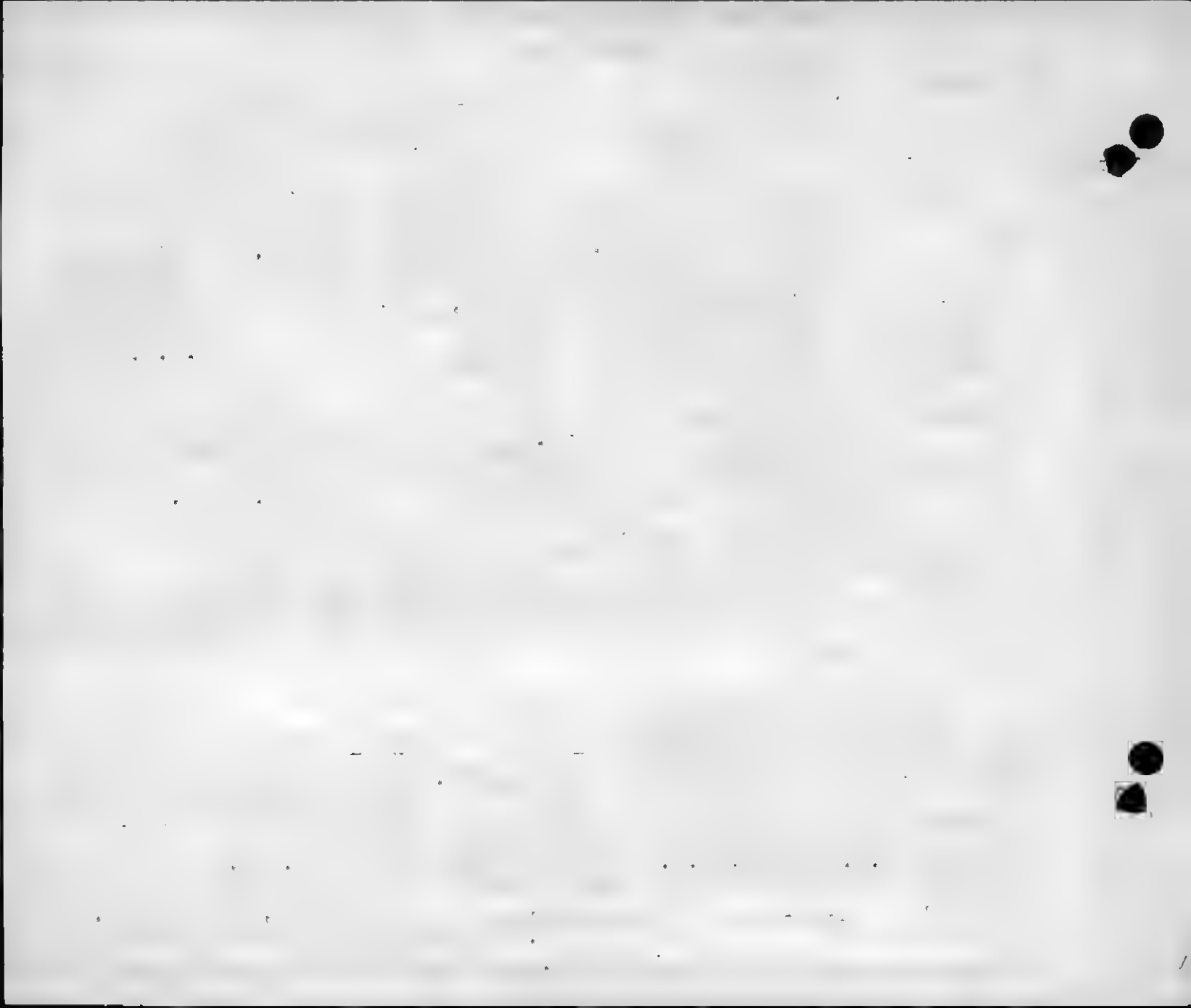
00205

CERTIFICATE OF DEATH

Reg. Dist. No. 00202

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 1/2 Winters Lane		d. STREET ADDRESS 60 1/2 Winters Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle F. Last BANKS		4. DATE OF DEATH Month Jan. Day 10 Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1891
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR: Months 70 Days 10 Hours 16 Min. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Ross		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs. Gertrude Smith 60 1/2 Winters Lane	
17. INFORMANT Mrs. Gertrude Smith 60 1/2 Winters Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency DUE TO 2 yrs. 1 Mo. 16 Days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Renal Disease DUE TO ? (c) ?		INTERVAL BETWEEN ONSET AND DEATH 16 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from II-25-59 , 19____, to I-10-62 , 19____, that I last saw the deceased alive on I-10-62 , 19____, and that death occurred at 8:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Winters Lane DATE SIGNED I-10-62			
ACTUAL SIGNATURE C.F. Maloney, M.D.		PHYSICIAN'S NAME (Type) C.F. Maloney, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-13-62	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hinkle		24a. REC'D BY REGISTRAR JAN 16 '62	
ADDRESS 578 W. Biddle St.		24b. REGISTRAR'S SIGNATURE Charles P. Hinkle	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
00206

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00203

1. PLACE OF DEATH a. COUNTY MARYLAND Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 3 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS BOX 153			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First FRANK Middle HERBERT Last BARNES				4. DATE OF DEATH Month JANUARY Day 4 Year 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 11, 1893	
9. AGE (In years last birthday) 68 yrs		10. IF UNDER 1 YEAR Months 6 Days 18		11. IF UNDER 24 HRS Hours 18 Min 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown - retired				10b. KIND OF BUSINESS OR INDUSTRY Unknown			
11. BIRTHPLACE (State or foreign country) TROY, NEW YORK				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME FRANK BARNES, SR				14. MOTHER'S MAIDEN NAME HARRIET HOLBROOK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO. 093-05-7466			
17. INFORMANT Hospital Records, Mt. Wilson State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF LUNG 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: PULMONARY TUBERCULOSIS INTERVAL BETWEEN ONSET AND DEATH one year 2 years							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/5 , 19 61 , to 1-4 , 19 62 that (I) (we) last saw the deceased alive on JAN. 4 , 19 62 , and that death occurred at 6:30 P. M. from the causes and on the date stated above.							
22a. SIGNATURE W. Murman				22b. DATE SIGNED Jan 11/62			
22c. PHYSICIAN'S NAME (Type) W. Murman, M.D. Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, (REMOVAL) Specify 1-4-62				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY Elmwood Troy, N.Y., N.Y.				23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Powell				25a. REC'D BY REGISTRAR Jan 8 '62			
ADDRESS Pulaski St				25b. REGISTRAR'S SIGNATURE C. L. & K. W.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

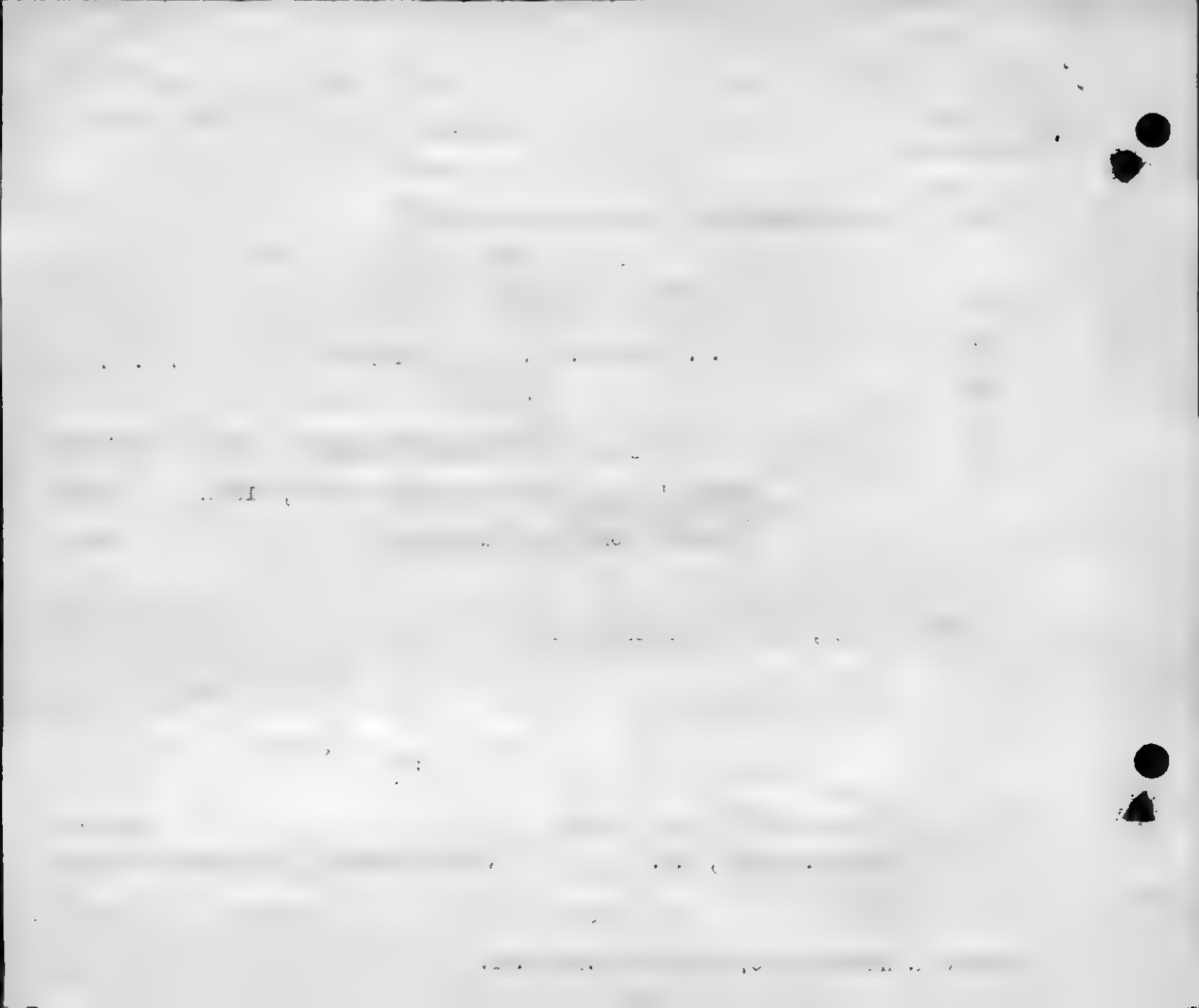
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00207

00204

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard		c. LENGTH OF STAY IN 1b 294		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS Box 288 RR 1		4. DATE OF DEATH Month January		Day 11		Year 19 62	
3. NAME OF DECEASED (Type or print) EDWARD C. BAUER		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1897	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Exp. Sta. Relay, Maryland		11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 64 yrs Months Days Hours Min.	
13. FATHER'S NAME Louis Bauer		14. MOTHER'S NAME Mary Phitzmeyer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-09-2315		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 201X XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO HODGKIN'S DISEASE INVOLVING LYMPH NODES, LIVER, KIDNEYS AND BONES PULMONARY CONGESTION AND EDEMA		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		RECENT		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UROLITHIASIS, WITH CHRONIC CYSTITIS		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (X) (this hospital) attended the deceased from March 23 to January 11, 1962 , that (X) (we) last saw the deceased alive on January 11, 1962 , and that death occurred at A. M. from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Crahan, M.D.		22b. DATE SIGNED 1/11/62		22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18 MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county)		(State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkins Ave. Balto. Md.		25a. REC'D BY REGISTRAR Jan 16 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00205

00208

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Randallstown</i>	
c. LENGTH OF STAY IN 1b <i>4 mos.</i>		d. STREET ADDRESS <i>9121 Bengal Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9121 Bengal Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>William Henry</i> Last <i>Bender</i>		4. DATE OF DEATH Month <i>January</i> Day <i>18</i> Year <i>62</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 28, 1913</i>
9. AGE (In years last birthday) <i>48 yrs.</i>		IF UNDER 1 YEAR Months <i>4</i> Days <i>8</i> Hours <i>15</i> Min.	IF UNDER 24 HRS Months <i>4</i> Days <i>8</i> Hours <i>15</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Free Writer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Rendix Radio</i>	
11. BIRTHPLACE (State or foreign country) <i>Fort Wayne Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George I. Bender</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Honeich</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>305-14-5959</i>	
17. INFORMANT <i>Mr. Allen Perkor</i>		Address <i>759 McKevins Ave. Balto 18</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA.</i> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>MYOCARDIAL INFARCTION</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 HR.</i> <i>1 HR.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>1</i> o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 20, 1961</i> , to <i>JAN 18, 1962</i> , that I last saw the deceased alive on <i>JAN 18, 1962</i> , and that death occurred at <i>12:20 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ronald Berger</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>8501 LIBERTY RD. Balto. Md.</i>	
PHYSICIAN'S NAME (Type) <i>RONALD BERGER, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Research</i>		22b. DATE THEREOF <i>1-18-1962</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>John Hopkins Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Spring Byers</i>		ADDRESS <i>8728 Liberty Road Randallstown, Md.</i>	
24a. REC'D BY REGISTRAR <i>JAN 22 1962</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00203

00206

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest		c. LENGTH OF STAY IN It 45 years		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest		d. STREET ADDRESS 7440 Bay Front Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CATHERINE AGNES BIRMINGHAM		First		Middle		Last		4. DATE OF DEATH January 14th, 1962		Month		Day		Year			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Maley		14. MOTHER'S MAIDEN NAME Delia Durkin		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT M.J. Birmingham, Sr., same as #2		Address			
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a). 4. Myocardial infarction DUE TO (b) Arteriosclerotic Cardiovascular disease DUE TO (c) 10 years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH 5 minutes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) examined attended the deceased from July 15th, 1960 to January 14, 1962 that (I) was last saw the deceased alive on January 14, 1962 and that death occurred at 4 A.M. from the causes and on the date stated above.																	
22a. SIGNATURE John V. Conway								M.D.		22b. DATE SIGNED 1/15/62		22c. PHYSICIAN'S NAME (Type) John V. Conway, M.D.		22d. ADDRESS 914 D Street, Sparrows Point 19,			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/62		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemty.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		25a. REC'D BY REGISTRAR DATE JAN 17 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna		25c. DATE			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00210

CERTIFICATE OF DEATH

00207

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Garrison</u> c. LENGTH OF STAY IN TB <u>?</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairleigh Nursing</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>6 Upland Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lulu R. Biscoe</u>		4. DATE OF DEATH Month Day Year <u>Jan 10 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 24 1872</u> <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>	
13. FATHER'S NAME <u>Phillip Dingle Dine</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>MRS. EDWARD B. WRIGHT</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis Heart Disease</u> (c) <u>Senility</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Sec. Arteriosclerosis</u>			
20a. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 14 1961</u> to <u>Jan 10 1962</u> that (I) (we) last saw the deceased alive on <u>JAN 10 1962</u> and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>H. W. Jenkins</u> M.D.		22b. DATE SIGNED <u>1-10-62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>JAN 13, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE</u> <u>MO.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H.W. JENKINS & Sons Co. 4905 YORK RD BALTO</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>G. J. Hunt & Sons</u>			

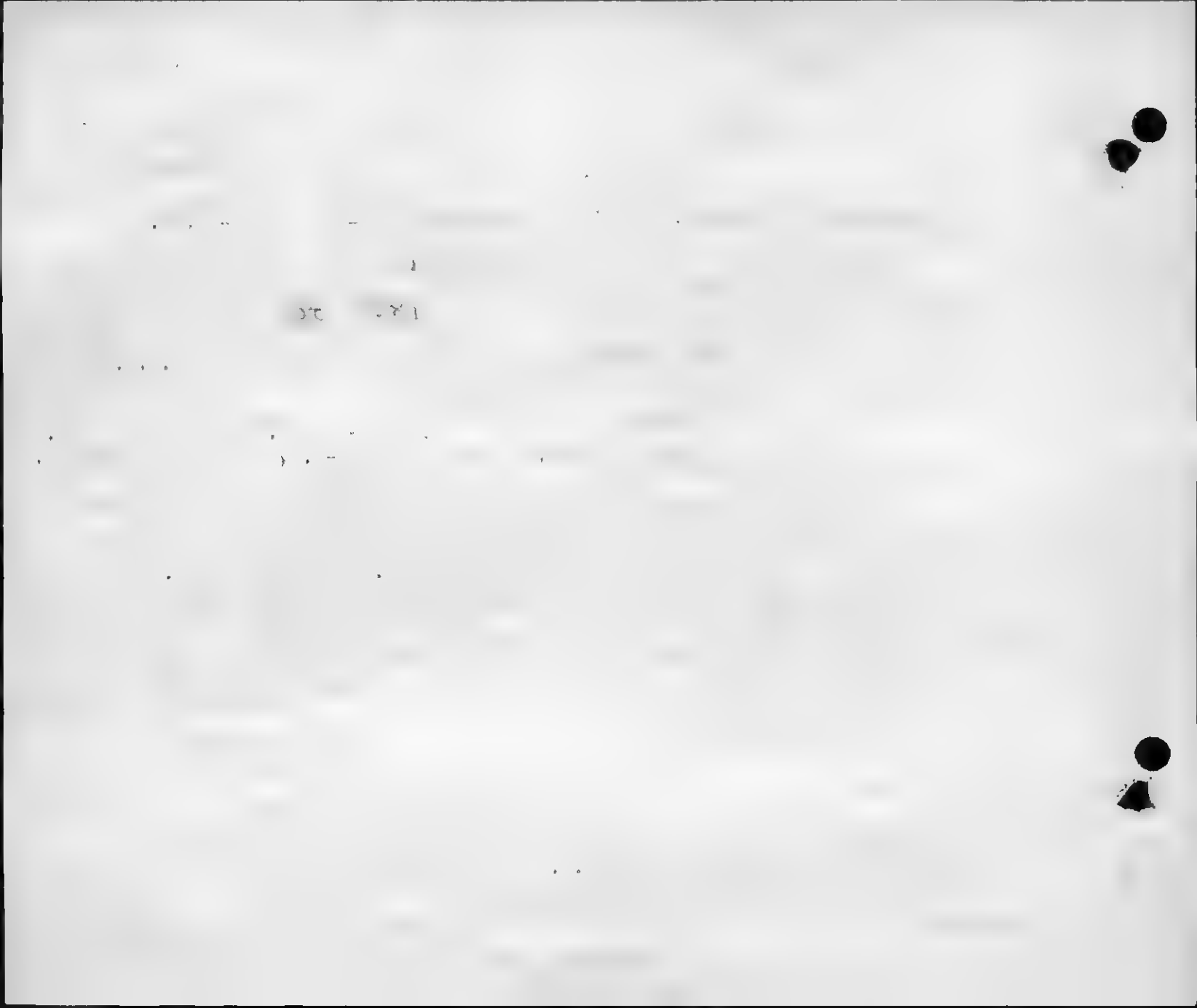
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00211 CERTIFICATE OF DEATH 00208											
1. PLACE OF DEATH a. COUNTY Baltimore City MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore City							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN IL March 17, 1958				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS Rosebank Road - Baltimore-22, Md.				15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary				4. DATE OF DEATH January 20, 1962				9. AGE (In years, if under 1 year; if under 24 hrs., last birthday) 1881 80 yrs. Months Days Hours Min.			
5. SEX Female				6. COLOR OR RACE white				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (Country & State, or foreign country) Maryland			
13. FATHER'S NAME Henry SCHULTZ				14. MOTHER'S MAIDEN NAME Mary ?				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Mr. Steven BLACK (son) - Box 8203, Rosebank Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH sudden			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute Heart Failure				DUE TO (b) Arteriosclerotic Cardio Vascular Disease with Aortic and Mitral Insufficiency. Myocardial Damage.				DUE TO (c) none			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				21. I certify that (I) (this hospital) attended the deceased from March 17, 1958 , to January 20, 1962 that (I) (we) last saw the deceased alive on 19 , and that death occurred at 11 M, from the causes and on the date stated above.			
22a. SIGNATURE Imre Kopits				22b. ADDRESS Imre KOPITS, M.D. Hospital				22c. PHYSICIAN'S NAME (Type) Imre KOPITS, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1/22/62				23c. NAME OF CEMETERY OR CREMATORY SACRED HEART			
24. FUNERAL DIRECTOR'S SIGNATURE B.W. Hoffmann				24b. ADDRESS 3218 HUDSON St.				25a. REC'D BY REGISTRAR JAN 23 '62			
25b. REGISTRAR'S SIGNATURE Chas. A. Pugh				25c. LOCATION (City, town or county) BALTO. Co.				25d. (State) MD.			



TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00212										
00209										
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Holbrook c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chapel Hill Nursing Home					2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 5713 Stonington Avenue #7					
3. NAME OF DECEASED (Type or print) Alton G Blackburn					4. DATE OF DEATH January 6, 1962					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male					6. COLOR OR RACE White					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired					10b. KIND OF BUSINESS OR INDUSTRY Construction					11. BIRTH-PLACE (County & State or foreign country) Virginia
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown					12. CITIZEN OF WHAT COUNTRY? U. S. A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. *****					17. INFORMANT Mr. Stanley Blackburn-5713 Stonington Avenue
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Arteriosclerotic cardiovascular disease DUE TO (c) Diabetes mellitus					INTERVAL BETWEEN ONSET AND DEATH 24 hrs.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) *****					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. [City or town] (County) (State)					20g. [City or town] (County) (State)					20h. [City or town] (County) (State)
21. I certify that (I) Millard T. Traband, Jr. attended the deceased from Jan. 5, 1962 to Jan. 5, 1962 that (I) last saw the deceased alive on Jan. 5, 1962 , and that death occurred at 11 A.M. from the causes and on the date stated above.										
22a. SIGNATURE Millard T. Traband, Jr.					22b. DATE SIGNED 1/6/62					22c. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 1-9-62					23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickens					24b. ADDRESS Woodlawn, Maryland					25a. REC'D BY REGISTRAR JAN 8 '62
25b. REGISTRAR'S SIGNATURE William J. Lickens					25c. REGISTRAR'S SIGNATURE William J. Lickens					25d. REGISTRAR'S SIGNATURE William J. Lickens



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00213

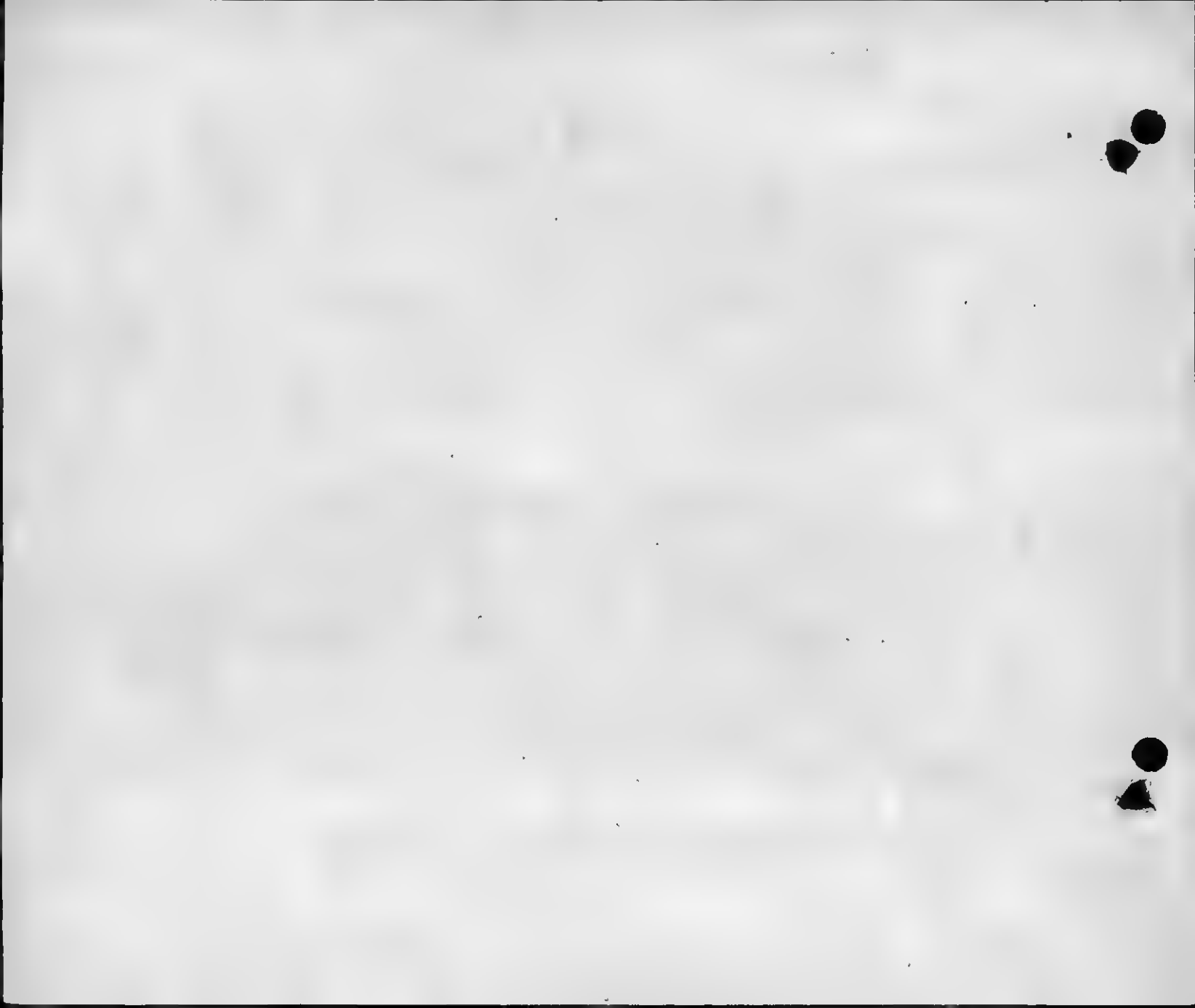
CERTIFICATE OF DEATH

00210

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN Baltimore d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines, 16 Fusting Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1708 Rolling Road, South	
3. NAME OF DECEASED (Type or print) First Richard Middle F. Last Bond 5. SEX male 6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 16, 1888 9. AGE (In years IF UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) 73 yrs. 10. DATE OF DEATH January 11, 1962	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) real estate & ins.		11. BIRTHPLACE (County & State, or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard H. Bond		14. MOTHER'S MAIDEN NAME Lillian Furnass	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) no		16. SOCIAL SECURITY NO. none 17. INFORMANT Florence I. Bond, 1708 S. Rolling Rd. #27 WIFE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 420 DUE TO terminal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Chr Myocarditis Dilated Hypertension DUE TO Hemoral arterio sclerosis Coronary artery disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Paroxysmal Supraventricular Tachycardia		INTERVAL BETWEEN ONSET AND DEATH 5 days 6 mo 2 mo 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 1540	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off campus, etc.) 20f. (City or town) Baltimore (County) Baltimore (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1962 to Jan 11, 1962 that (I) (we) last saw the deceased alive on Jan 11, 1962, and that death occurred at 4:30 PM, from the causes and on the date stated above.			
22a. SIGNATURE Bruce Brumbaugh, M. D. 22c. PHYSICIAN'S NAME (Type) Bruce Brumbaugh, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 5609 Main St. Elkridge 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/15/62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue #29		25a. REC'D BY REGISTRAR JAN 16 '62	
25b. REGISTRAR'S SIGNATURE J. S. Kraus		26. DATE JAN 16 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00214

00211

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN 15

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Towson 4

d. STREET ADDRESS

1300 Red Fox Court

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

January 6 19 62

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

☒ NEVER MARRIED ☐

8. DATE OF BIRTH

Sept. 6, 1896

9. AGE (In years, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.
65 yrs Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Automotive Jobber

10b. KIND OF BUSINESS OR INDUSTRY

Self employed

11. BIRTHPLACE (County & State, or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Boyd

14. MOTHER'S MAIDEN NAME

Annie Bray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

WW I

16. SOCIAL SECURITY NO.

216-32-7186 Mrs. Louise E. Boyd, 1300 Red Fox Ct. Towson 4

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

MYOCARDIAL INFARCTION

INTERVAL BETWEEN ONSET AND DEATH
1 HOUR

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) ARTERIOSCLEROTIC HEART DISEASE

DEAR

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 1957 to JAN 6, 1962, that (I) (we) last saw the deceased alive on DEC 29, 1961, and that death occurred at 12:30 AM, from the causes and on the date stated above.

22a. SIGNATURE

Adam G. Swiss

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☒

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

ADAM G. SWISS

22d. ADDRESS

6232 BELAIR ROAD, BALTO 6, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

1-9-62

23c. NAME OF CEMETERY OR CREMATORY

New Cathedral Cemetery

23d. LOCATION (City, town or county)

Baltimore

24. FUNERAL DIRECTOR'S SIGNATURE

Wm. Cook-Towson, Inc., 1050 York Road, TOWSON

25a. REC'D BY REGISTRAR

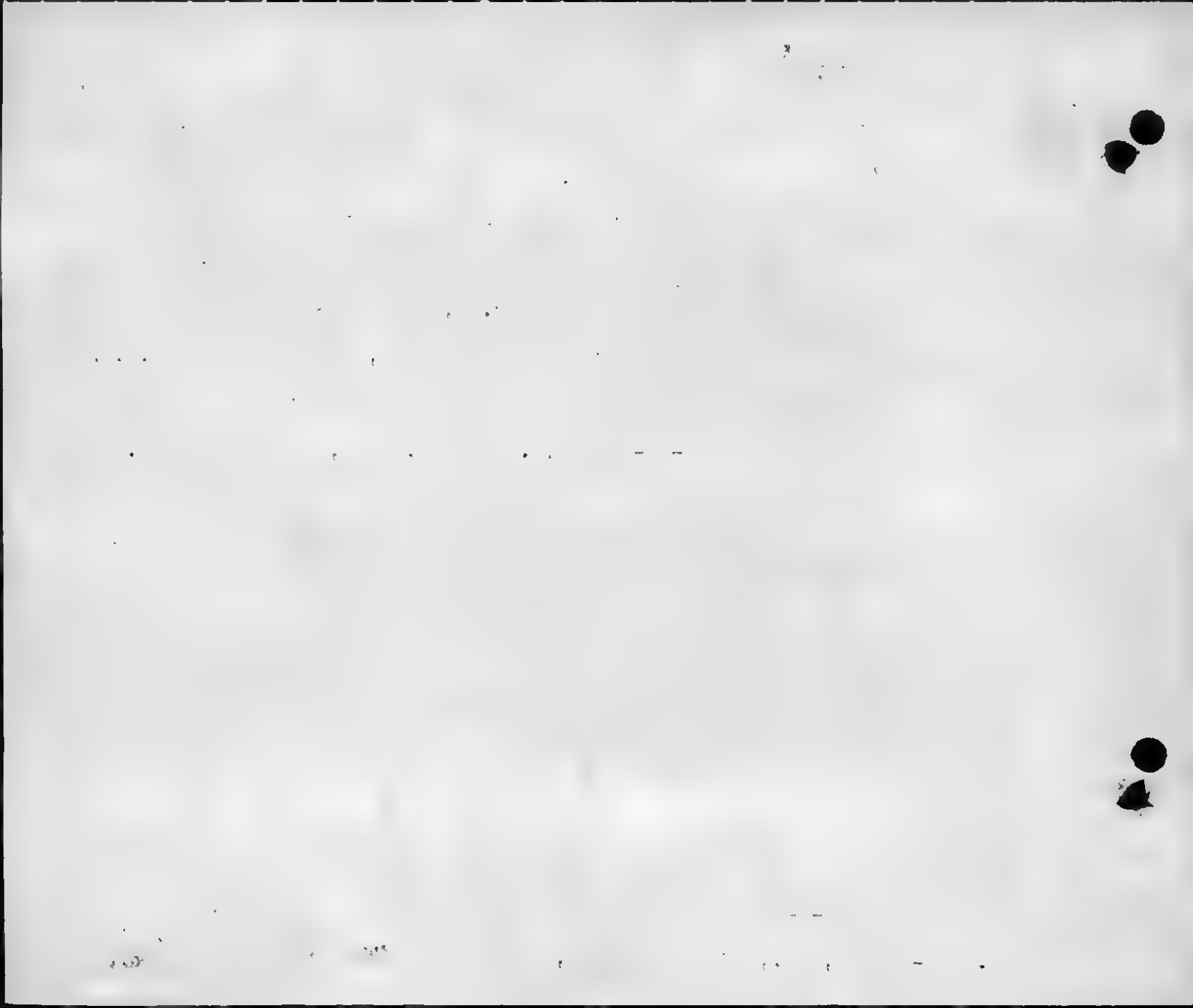
DATE JAN 9 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/68



VR A1E (4)
15M 9/59

00215

00212

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wt. Wilson, Md.		c. LENGTH OF STAY IN 1b 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADAM (BRUKIEWA) Brooks Last		4. DATE OF DEATH Month 1 Day 27 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/3/1905
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9b. AGE (In years last birthday) yrs. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES - BRUKIEWA		14. MOTHER'S MAIDEN NAME MA - CIESLAK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-8939	
17. INFORMANT Hospital Records, Wt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung with Metastases; and DUE TO massive Hemorrhage Pulmo. T.B. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002.1			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-29-1961 to 1-27-1962 that (I) (we) last saw the deceased alive on 1-27-1962 and that death occurred at 1 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 1/27/62	
22c. PHYSICIAN'S NAME (Type) Newcomer, M.D. Superintendent		22d. ADDRESS Wt. Wilson State Hospital, Wt. Wilson, Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 30-1962	
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town, or county) (State) A.A. Co. Brooklyn, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George A. Weber		25a. REC'D BY REGISTRAR DATE JAN 29 1962	
ADDRESS 705 SOUTH ANN ST		25b. REGISTRAR'S SIGNATURE John J. Finner	



TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Even please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00216 CERTIFICATE OF DEATH 00213											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>#4</u>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Armaccost Nursing Home</u>			d. STREET ADDRESS <u>323 Dixie Drive</u>			e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Blanche</u>			First Middle Last <u>H. Browning</u>			4. DATE OF DEATH <u>January 20, 1962</u>					
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Dec. 13, 1878</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days <u>10</u> <u>20</u>			
13. FATHER'S NAME <u>James Frist</u>			14. MOTHER'S MAIDEN NAME <u>Annie Amelia Beam</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>10</u>			17. INFORMANT <u>Mrs. Marguerite Smith- 323 Dixie Drive #4</u>					
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>10 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yrs.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Pikesville, Md.</u>		(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17, 1962</u> to <u>Jan 20, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 17, 1962</u> and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Arthur L. Haines</u> M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>JAN 22 '62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Arthur L. Haines</u>			22d. ADDRESS <u>1009 N. Frederick Ave. Baltimore 17, Md.</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>1-23-62</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Pikesville, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sam J. Haines & Sons</u>			ADDRESS <u>Baltimore 17, Md.</u>			25a. REC'D BY REGISTRAR <u>JAN 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

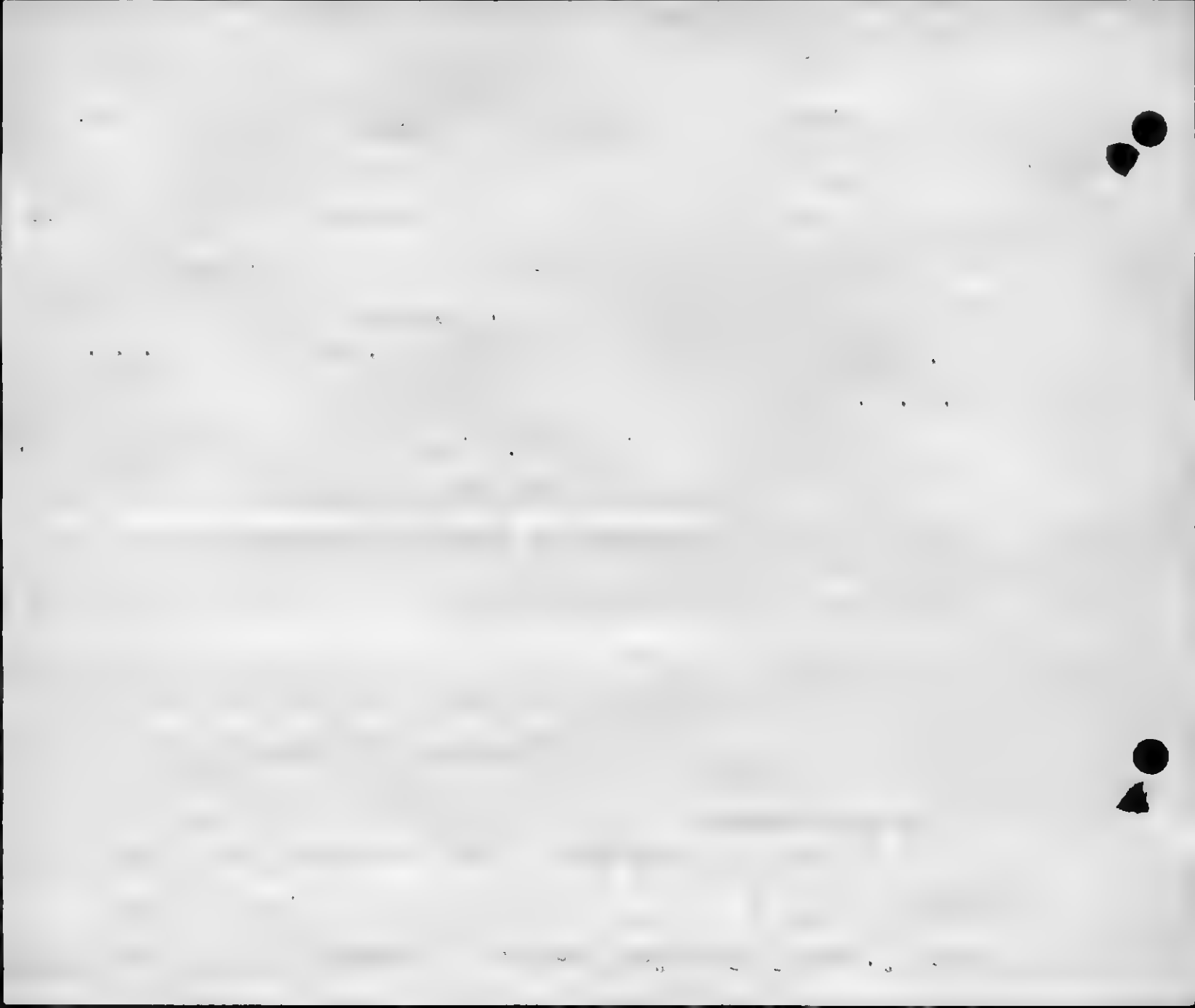
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00217

CERTIFICATE OF DEATH

00214

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>529 Old Home Road</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u> d. STREET ADDRESS <u>529 Old Home Road</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Charles Henry Buckley</u>		4. DATE OF DEATH <u>January 25th 1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 27, 1867</u>	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <u>94 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Mechanical Engineer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Shappsburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. J. W. Buckley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Rishel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220/05/6239</u>	
17. INFORMANT <u>Mr. Rishel Buckley</u>		Address <u>529 Old Home Road.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420) DUE TO Condition (if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 4, 1952</u> to <u>Jan 25, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 24, 1962</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George Sawyer</u>		22b. DATE SIGNED <u>1/25/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>GEORGE SAWYER - M.D.</u>		22d. ADDRESS <u>4808 Harford Rd. Balto 14</u>	
23a. BURIAL, CREMATION, <u>Burial</u>		23b. DATE THEREOF <u>1/27/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>JAN 29 '62</u>	
ADDRESS <u>5305 Harford Road #14</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9,60

Item 18 File # 3-10-62

1-6-62

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11/215

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middle River
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 25 Glenwood Court

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore County
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Middle River
d. STREET ADDRESS 25 Glenwood Court

3. NAME OF DECEASED (Type or print) JOHN
First Middle Last
4. DATE OF DEATH January 16, 1962
Month Day Year
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 3-4-1915
WIDOWED ☐ DIVORCED ☒ 9. AGE (In years last birthday) 46 yrs. IF UNDER 1 YEAR, IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO MECHANIC 10b. KIND OF BUSINESS OR INDUSTRY AUTO REPAIR 11. BIRTHPLACE (State or foreign country) NEW JERSEY 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME STANLEY BUKRY 14. MOTHER'S MAIDEN NAME JOSEPHINE OHARA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 215-16-9601 17. INFORMANT PAUL CORSIGLIA RD 5 TUCKAHOE RD N.J. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
42.1 } DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
(b) Arteriosclerotic cardiovascular disease
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease
(b) Arteriosclerotic cardiovascular disease
(c) Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Howard G. Shaub M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED 1/16/62

EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D. Address (Street, city, town, or county) (City, town, or county) (State)

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 1-18-62 22c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEM. 22d. LOCATION (City, town, or county) BALTO, MD.

23. FUNERAL DIRECTOR Lassahn Sam'l Home 7401 Belair Rd. ADDRESS 24. REC'D BY REGISTRAR JAN 19 '62 24b. REGISTRAR'S SIGNATURE [Signature]



TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove page 4 and 5 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-10-62
00219
00216

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

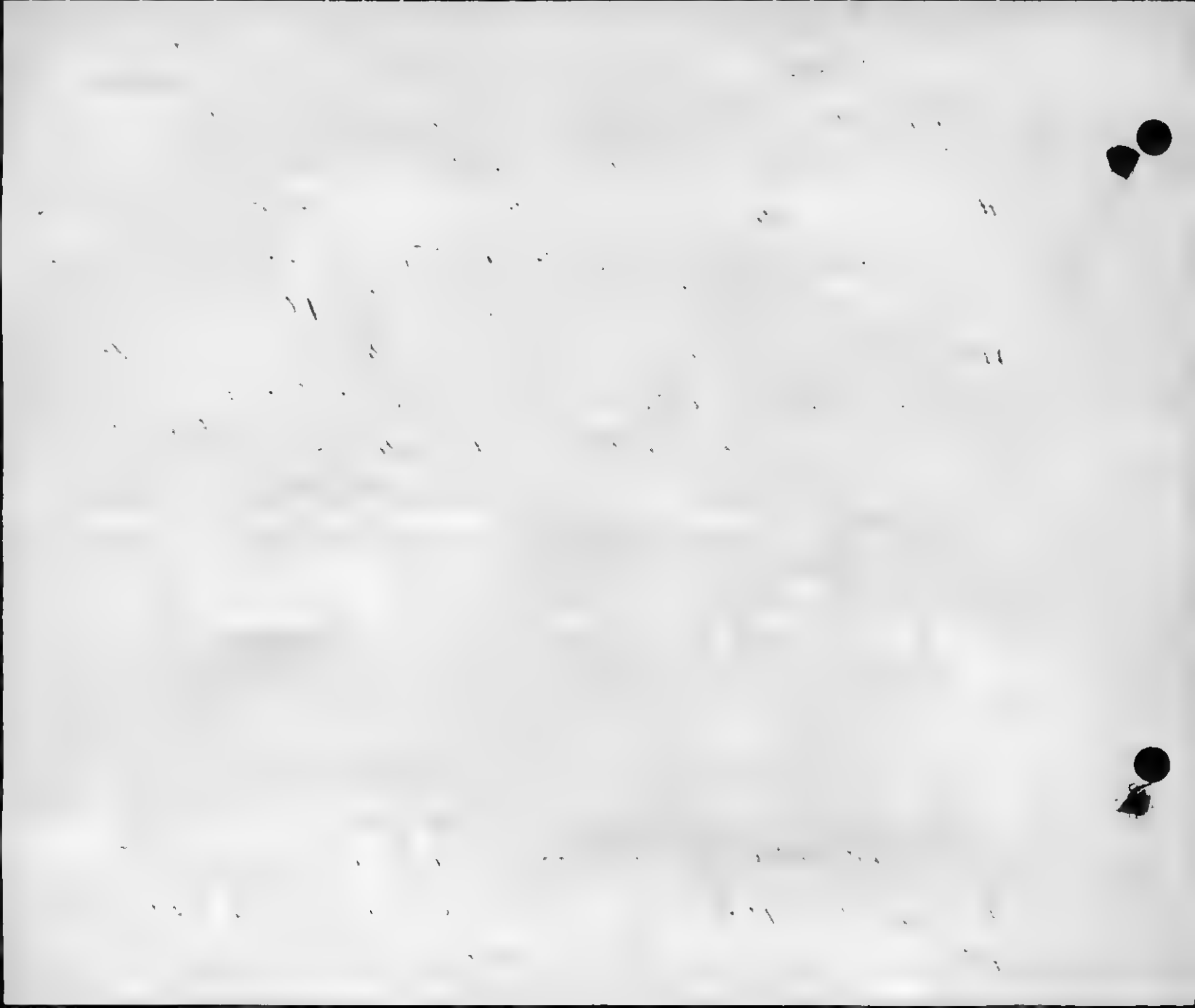
1. PLACE OF DEATH
a. COUNTY **BALTIMORE, CO.** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **OWINGS MILLS, MD.** 5 MONTHS
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **#2 DOLL LANE**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **MARYLAND** b. COUNTY **BALTO.**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **OWINGS MILLS**
d. STREET ADDRESS **#2 DOLL LANE**

3. NAME OF DECEASED (Type or print) **JANICE ELIZABETH BURKETT**
First Middle Last
4. DATE OF DEATH **JAN. 17 1962**
Month Day Year
5. SEX **F** 6. COLOR OR RACE **W** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **4/28/45** 9. AGE (In years last birthday) **16** yrs. F UNDER 1 YEAR; IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **WAITRESS** 10b. KIND OF BUSINESS OR INDUSTRY **RESTAURANT** 11. BIRTHPLACE (County & State or foreign country) **MARYLAND** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**
13. FATHER'S NAME **WILLIAM A. CLEMENTS** 14. MOTHER'S M maiden name **MYRIEL RUTH BOSLEY**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) **215-42-9039** 16. SOCIAL SECURITY NO. **MR. SHERMAN BOSLEY JR.** Address **FINKSBURG, MD.**

18. CAUSE OF DEATH [Enter only one cause part (a) for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **754.5** DUE TO **CONGENITAL HEART DISEASE**
Conditions if any were given rise to immediate cause (a), stating the underlying cause last. (b) **CONGENITAL HEART DISEASE** DUE TO **CONGENITAL HEART DISEASE**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **Delivered an infant spontaneously** 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **1-17-62** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **1-1-48** 20f. (City or town) **1-1-48** (County) **1-1-48** (State) **1-1-48**

21. I certify that (I) (this hospital) attended the deceased from **1-1-48** to **1-17-62**, that (I) (we) last saw the deceased alive on **1-17-62**, and that death occurred at **5:45** AM, from the causes and on the date stated above.
22a. SIGNATURE **James G. Saffell** M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. PHYSICIAN'S NAME (Type) **DR. JAMES G. SAFFELL** 22c. ADDRESS **64 MAIN ST. REISTERSTOWN, MD.**
23a. BURIAL, CREMATION, or other disposal (Specify) **BURIAL** 23b. DATE THEREOF **1/20/62** 23c. NAME OF CEMETERY OR CREMATORY **WESTMINSTER CEM.** 23d. LOCATION (City, town or county) **WESTMINSTER, MD.**
24. FUNERAL DIRECTOR'S SIGNATURE **James G. Saffell** ADDRESS **254 E. MAIN ST. WESTMINSTER, MD.** 25a. REC'D BY REGISTRAR **AM 19 '62** 25b. REGISTRAR'S SIGNATURE **William S. Finkle**



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

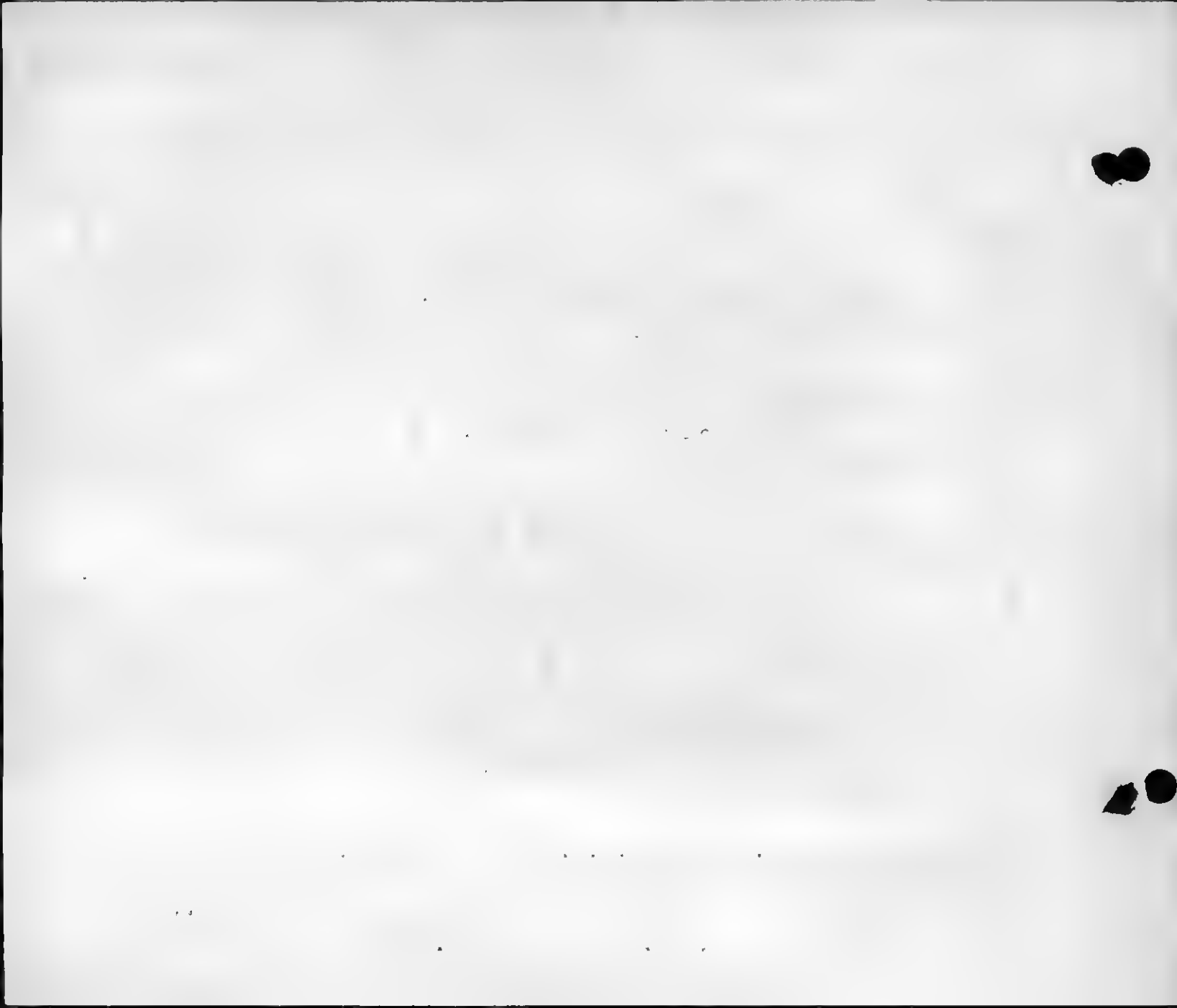
00220

CERTIFICATE OF DEATH

Reg. Dist. No. 00217

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b (22)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7101 Martell Avenue				e. STREET ADDRESS 7101 Martell Avenue			
3. NAME OF DECEASED (Type or print) First HENRY Middle DANIEL Last BUSH				4. DATE OF DEATH Month January Day 4th Year 1962			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 8, 1912	9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Out		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frederick Bush				14. MOTHER'S MAIDEN NAME Margaret Shipley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-07-0101		17. INFORMANT Ella A. Bush		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BREAST CANCER (4th) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY ARTERY DISEASE							INTERVAL BETWEEN ONSET AND DEATH 7 M.O
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1962 to Jan 4, 1962 that I last saw the deceased alive on Jan 3, 1962 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6714 Holabird Avenue DATE SIGNED 1/5/62							
ACTUAL SIGNATURE Stephen C. Mackowiak M.D.				DATE SIGNED 1/5/62			
PHYSICIAN'S NAME (Type) Stephen C. MACKOWIAK, M.D.				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6/62		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR JAN 8 '62		24b. REGISTRAR'S SIGNATURE W. L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00221 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00218

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>			
c. LENGTH OF STAY IN b. <u>6 years</u>				d. STREET ADDRESS <u>1209 CULVERT RD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LOCH RAVEN RESERVOIR</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GARY</u>		First <u>JOHN</u> Middle <u>BUTLER</u> Last <u>BUTLER</u>		4. DATE OF DEATH <u>JAN 2 1962</u>		Month <u>2</u> Day <u>1962</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-5-44</u>	
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life) <u>SCHOOL guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pool</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>J. Wilmer Butler</u>		14. MOTHER'S MAIDEN NAME <u>Lois Gettler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-42-6362</u>		17. INFORMANT <u>J. Wilmer Butler</u>		Address <u>1209 Culvert Rd 4</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACCIDENTAL DROWNING</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Fell through the ice while skating</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell through the ice while skating</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>1-2-</u> 19 <u>62</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Loch Raven Reservoir Towson Balto. Md.</u>		20f. (City or town) <u>Towson</u>		(County) <u>Balto.</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William A. Pillsbury</u>		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-3-62</u>	
EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Brooks Funeral Service, Inc Towson Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-5-1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Va. Mem Gardens</u>		22d. LOCATION (City, town, or country, State) <u>York Rd Cockeysville Md</u>	
23. FUNERAL DIRECTOR <u>Brooks Funeral Service, Inc Towson Md</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G305 1/10/62 iwa

CERTIFICATE OF DEATH

Reg. Dist. No. 00219

00222

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 7 Weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2202 Searles Road		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 2202 Searles Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROSE First Middle Last RYROADE		4. DATE OF DEATH Month Day Year JANUARY 2 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877 OCT 10, 1878
9. AGE (In years last birthday) yrs 84		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Apartment House	
11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Carney		14. MOTHER'S MAIDEN NAME Nancy Cameron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-22-9542	
17. INFORMANT Dean W. Byroade		Address 1127 H. Street Balt 19, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiac-vascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 day 30 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2 Jan 1962 to 2 Jan 1962 that I last saw the deceased alive on 2 Jan 1962 and that death occurred at 6:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Morrison M.D.		ADDRESS (Street, city or town, state) 3 Kinship Rd Dundalk Md. DATE SIGNED 4 Jan 62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-5-1962	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Cemt.	22d. LOCATION (City, town, or county) (State) Bel Air Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		24a. REC'D BY REGISTRAR JAN 8 '62 24b. REGISTRAR'S SIGNATURE John S. Thomas	

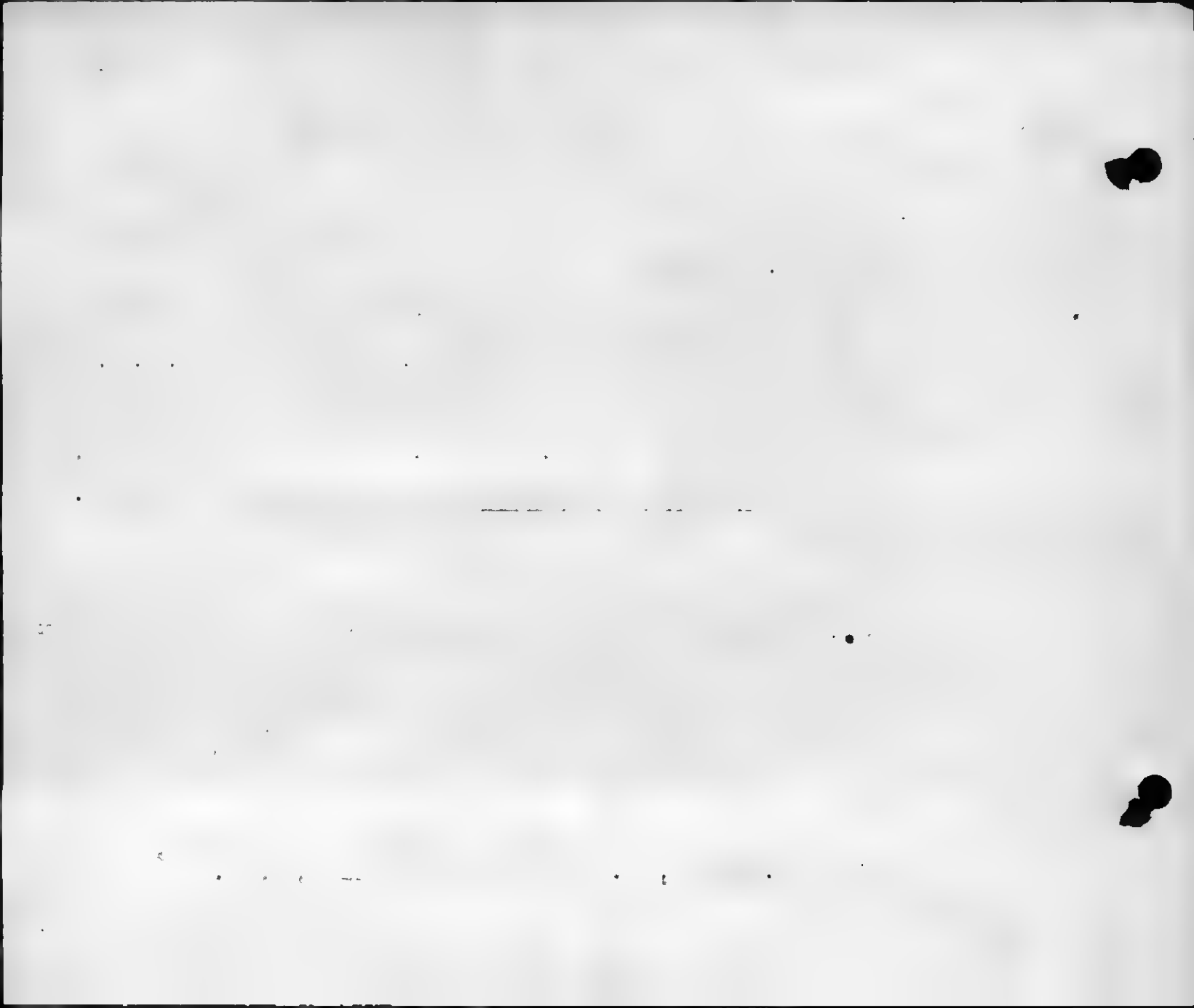
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VR A15 (4)
15M 9/60

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4. [redacted] be retained by the hospital or attending physician. Page 4.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

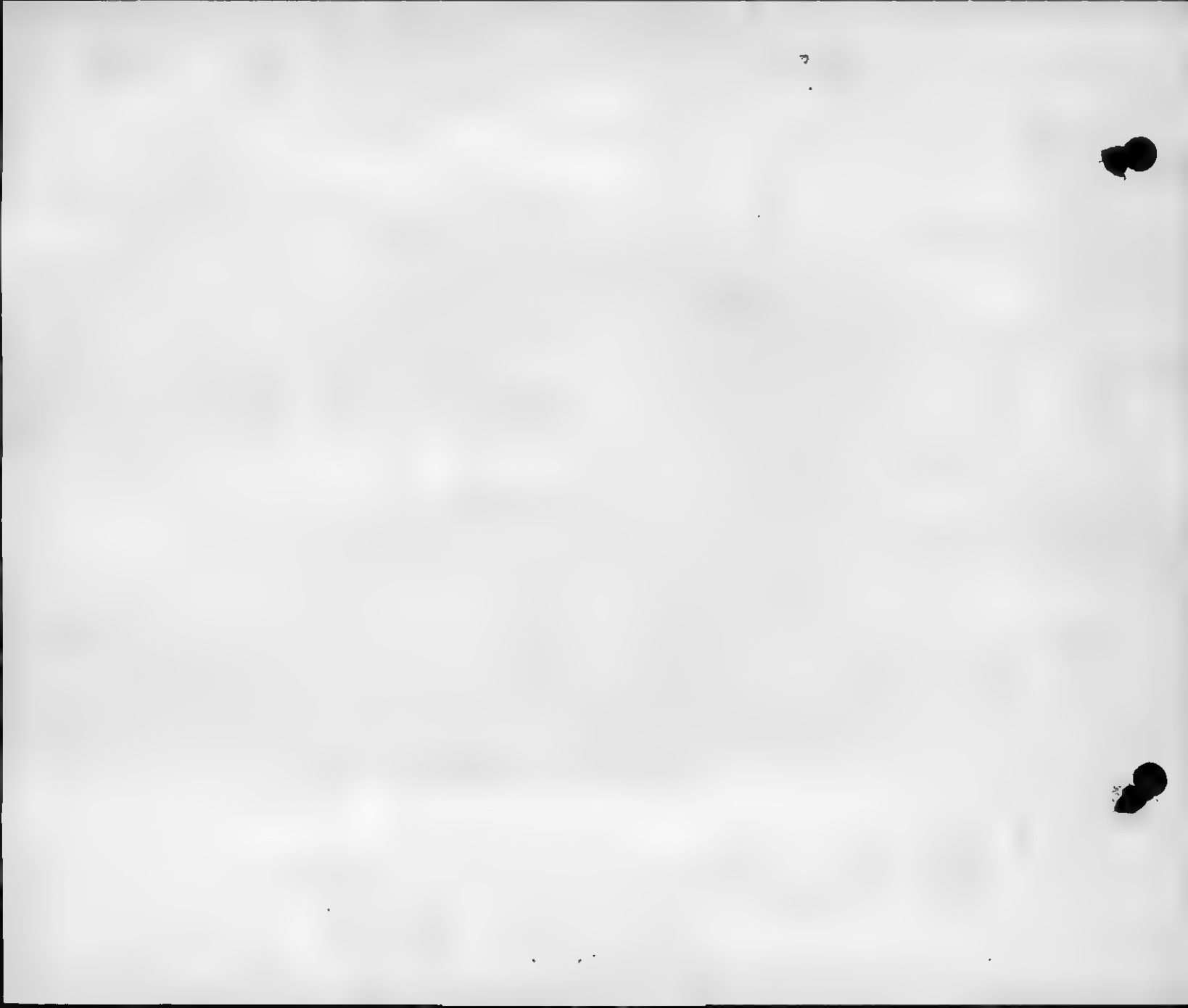
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5M 7/59

FOR STATE
HEALTH DEPT.

M

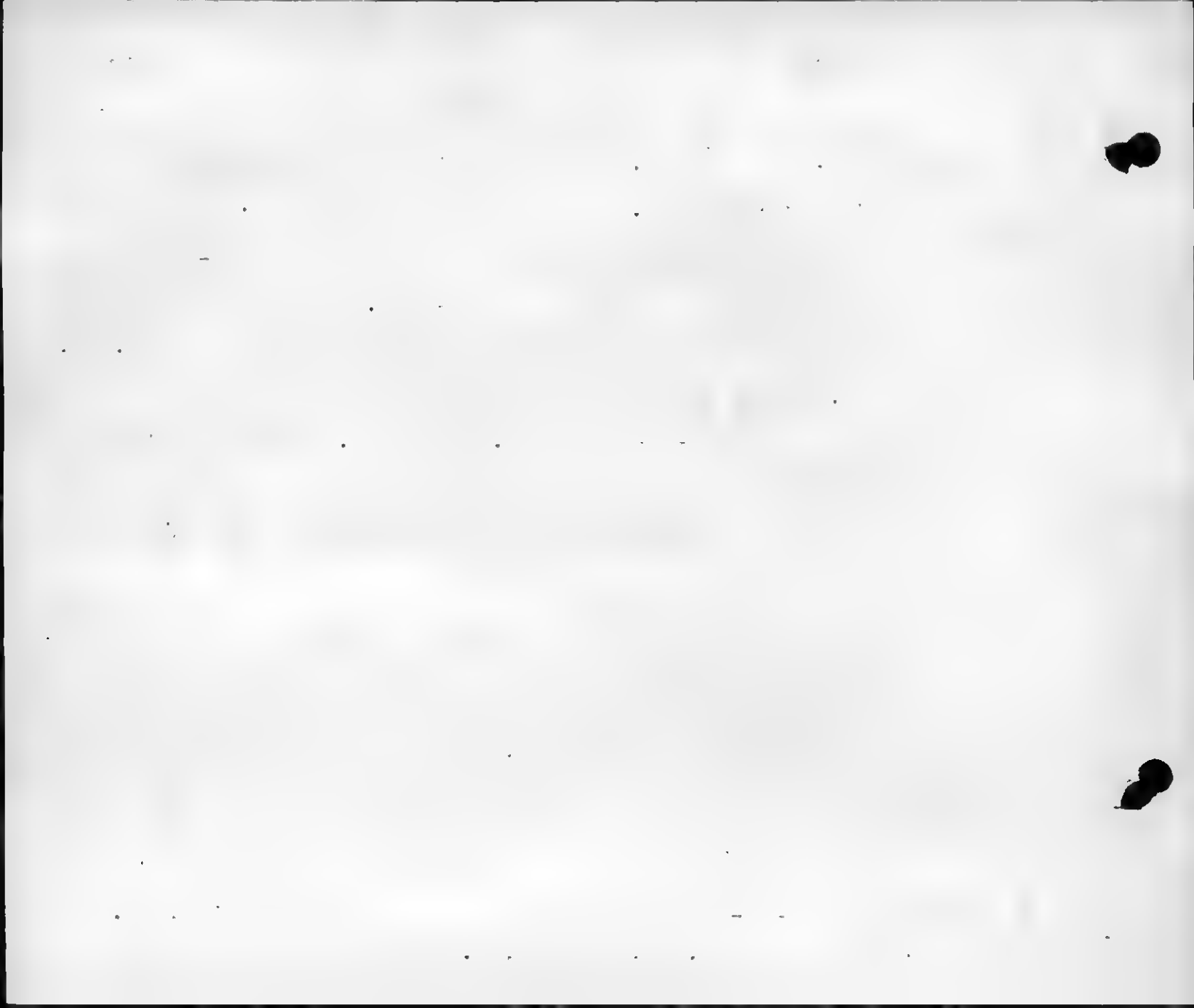
MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
BALTO.		MARYLAND		Md.		BALTO.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
RANDALLSTOWN 3722		3830 KILBURN RD.		RANDALLSTOWN		3830 KILBURN RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH		g. DATE OF BIRTH		h. AGE (In years last birthday)	
1962		Jan 24		Aug 29, 1907		54 yrs.	
i. NAME OF DECEASED (Type or print)		j. SEX		k. COLOR OR RACE		l. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
KATHARINE D.		Female		White			
m. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		n. KIND OF BUSINESS OR INDUSTRY		o. BIRTHPLACE (State or foreign country)		p. CITIZEN OF WHAT COUNTRY?	
Clerk		Electrical Contractor		BALTO		U.S.A.	
q. FATHER'S NAME		r. MOTHER'S MAIDEN NAME		s. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		t. SOCIAL SECURITY NO.	
Harry Tailor		Emma Marsh		No		219-10-6632	
u. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		v. INTERVAL BETWEEN ONSET AND DEATH		w. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		x. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		12 hrs					
422.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b)							
(c)							
y. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		z. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		aa. TIME OF INJURY Month, Day, Year		ab. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
None				None			
ac. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		ad. (City or town)		ae. (County)		af. (State)	
None		None		None		None	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23. ACTUAL SIGNATURE <i>R.D. Catles</i> M.D.				24. DATE SIGNED 1-24-62			
25. EXAMINER'S NAME (Type) R.D. CATLES				26. ADDRESS (Street, city, town, or county)			
27. 8728 Liberty Road Randallstown, Md.				28. REC'D BY REGISTRAR DATE JAN 26 '62			
29. 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Harris</i>							
30. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				31. 22b. DATE THEREOF 1/27/62			
32. 22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery				33. 22d. LOCATION (City, town, or country) Baltimore Maryland			
34. 23. FUNERAL DIRECTOR <i>Loring Byers</i>				35. 24a. REC'D BY REGISTRAR DATE JAN 26 '62			



00222

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12,		c. LENGTH OF STAY IN 1b yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 803 Tred Avon Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12, Stoneleigh	
3. NAME OF DECEASED (Type or print) GEORGE REVELL COLEBURN		4. DATE OF DEATH Month 1-9 Day 19 Year 62	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-24-1899.
9. AGE (In years last birthday) 62 yrs		10. F UNDER 1 YEAR Months Days Hours Min. F UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attorney		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert P. XXXXXX Coleburn		14. MOTHER'S MAIDEN NAME Martha Kelley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv ice) no		16. SOCIAL SECURITY NO 217-38-2730	
17. INFORMANT Mrs. Hermine H. Coleburn		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic pyelonephritis and gout Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 months DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 27 19 61 , to Jan. 9 19 62 that (I) (we) last saw the deceased alive on Jan. 9 19 62 , and that death occurred at 2:40 M, from the causes and on the date stated above.			
22a. SIGNATURE Anthony Albrecht		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ANTHONY ALBRECHT		22d. ADDRESS LOCHRAVEN SHOPPING CENTER, BALTIMORE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Interment		23b. DATE THEREOF 1-11-62	
23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town, or county) (State) Baltimore City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Inc., Towson 4, Md.		25a. REC'D BY REGISTRAR DATE JAN 10 '62	
25b. REGISTRAR'S SIGNATURE Wm. S. Evans			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00226

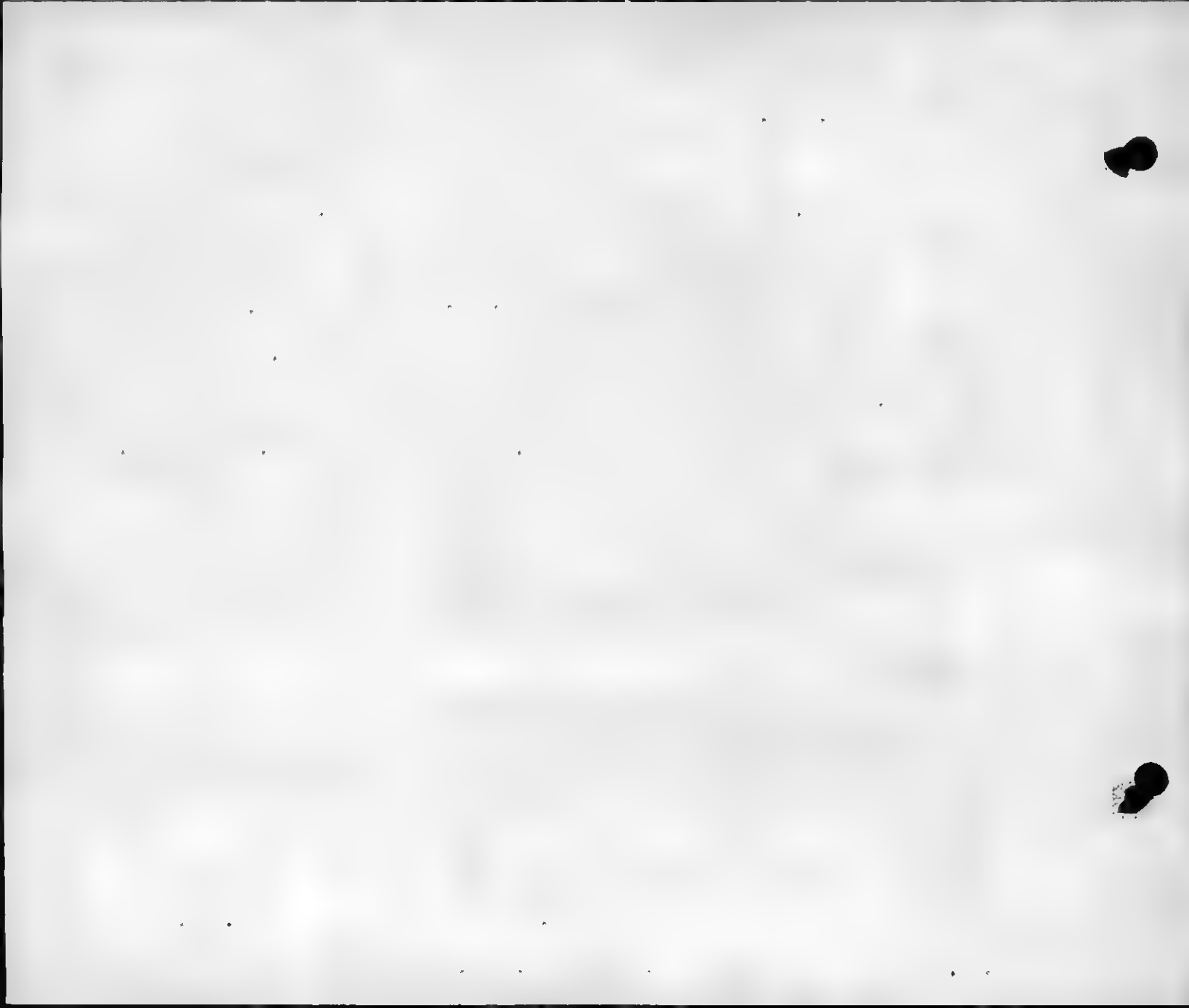
Items 3 & 9 Film G305 1/11/62 iwk

Reg. Dist. No.

00223

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Turners Station		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Balt Dundalk - Turners Station	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Avondale Rd.		d. STREET ADDRESS 107 Avondale Rd.	
3. NAME OF DECEASED (Type or print) Sabrina First Middle Cole Last		4. DATE OF DEATH Month 1/8/62 Day Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1956
9. AGE (In years last birthday) 6/4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Mins.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		11. BIRTHPLACE (State or foreign country) Baltimore City, Md.	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Alvin Wm. Coles		14. MOTHER'S MAIDEN NAME Helen Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Helen Cole		Address 2026 1st, Royal Terr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia			
DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital lack of muscular development			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack E. Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Jack E. Collins		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/62	
22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jm. A. Jackson		ADDRESS 916 Penna. Ave.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form 3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



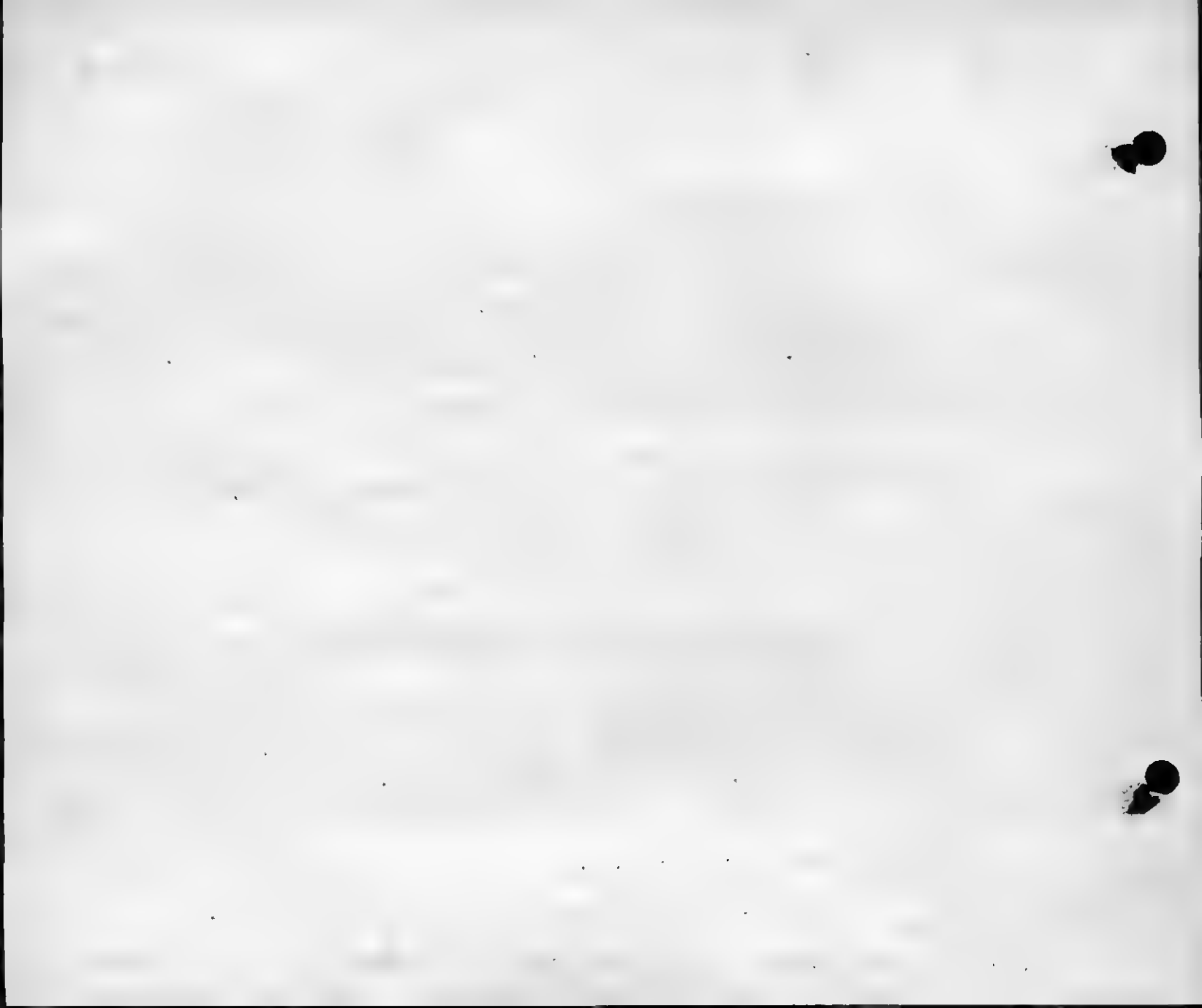
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00227 CERTIFICATE OF DEATH 00224									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>7 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if last full one: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>4108 Crittendon Street</u>				
3. NAME OF DECEASED (Type or print) <u>Ursa Compton</u>					4. DATE OF DEATH <u>January 30 1962</u>				
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>1876-11-1</u> 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <u>85 yrs.</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXXXXX Ret.</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Jewel Tr Co.</u> 11. BIRTHPLACE (County & State or foreign country) <u>VIRGINIA</u>				
13. FATHER'S NAME <u>Samuel B Compton</u>					14. MOTHER'S MAIDEN NAME <u>unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>					16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>190.9</u> IMMEDIATE CAUSE (a) <u>Multiple melanoma with widespread metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Original site undetermined)</u> DUE TO (c)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (this hospital) attended the deceased from <u>June 30 1961</u> to <u>Jan. 30 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 30 1962</u> , and that death occurred at <u>6:55 a.m.</u> from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED <u>1-30-62</u>				
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>					22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>2-2-62-</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Bealton</u>					23d. LOCATION (City, town or county) (State) <u>Bealton Va.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>					25a. REC'D BY REGISTRAR <u>Washington & Co</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles J. Hanks</u>					25c. DATE <u>1 '62</u>				



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00228

CERTIFICATE OF DEATH

00225

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last		4. DATE OF DEATH Month Day Year	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-18-0594	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ART.</u> DUE TO (b) <u>ART.</u> DUE TO (c) <u>ART.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE		25c. DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. Page 5 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00229

00226

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> <u>4 days</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> Anne Arundel b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>5 Washington Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
NAME OF DECEASED (Type or print) <u>ASHTON</u> 5. SEX <u>Male</u> <u>Negro</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 22 1893</u> 9. AGE (in years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Storage Company</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Delaplane, Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			4. DATE OF DEATH <u>January 28 1962</u> 13. FATHER'S NAME <u>Enoch Corum</u> 14. MOTHER'S MAIDEN NAME <u>Carrie Ashby</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW-1</u> 16. SOCIAL SECURITY NO. <u>214-05-2023</u> 17. INFORMANT <u>Clinical Records VA Hospital</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INFARCTIONS</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>7:05</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 24</u> , 1962, to <u>Jan. 28</u> , 1962, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Jan. 28</u> , 1962, and that death occurred at <u>7:05</u> a.m. from the causes and on the date stated above. 22a. SIGNATURE <u>Bernard N. Bathon</u> 22c. PHYSICIAN'S NAME (Type) <u>Bernard N. Bathon, M.D.</u> 22d. ADDRESS <u>3900 Loch Raven Blvd. Baltimore 18, Maryland. Fort Howard Division</u> 22b. DATE SIGNED 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-31-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> ADDRESS <u>1000 Brantley Ave. Balto. 17, Md.</u> 25a. REC'D BY REGISTRAR <u>JAN 31 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thayer</u>		

VR A15 (4)
15M 9/60



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in the mail "pending" in pencil in Item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

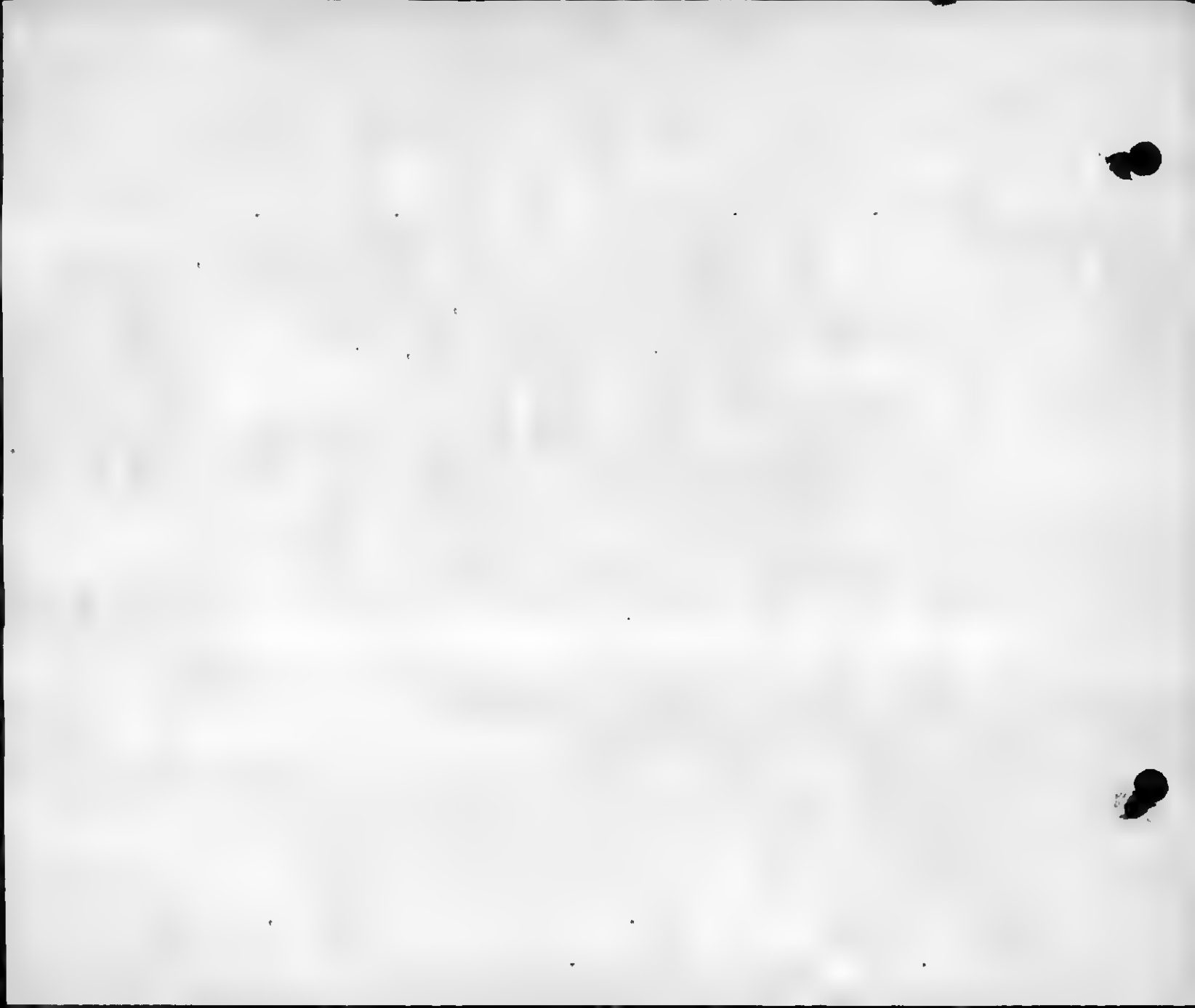
00230

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00227

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. (If Institution) Residence before admission) a. STATE Baltimore b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Essex (21)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 375 S. Marlyn Ave.				d. STREET ADDRESS Box 375 S. Marlyn Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anthony James Dausch				4. DATE OF DEATH Month Day Year January 25, 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 24, 1900	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Dausch				14. MOTHER'S MAIDEN NAME Matilda ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11		16. SOCIAL SECURITY NO. 219-01-3026		17. INFORMANT Address Veteran's Administration Fayettee & St. Paul St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Dis. + 20 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/62		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski				24a. REC'D BY REGISTRAR JAN 31 '62		24b. REGISTRAR'S SIGNATURE 1-2962	
25. FUNERAL HOME ADDRESS 1407 Eastern Ave.							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

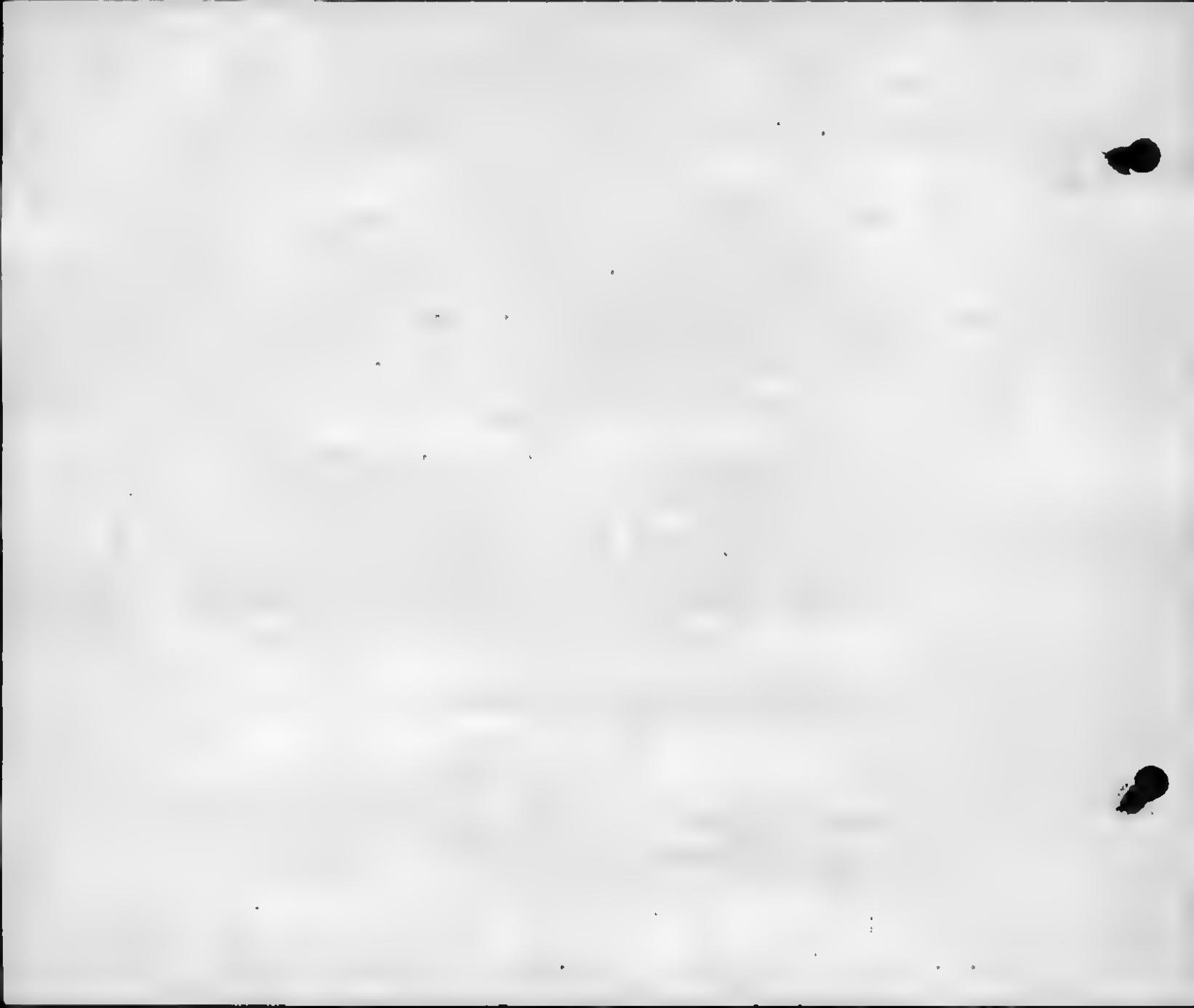
CERTIFICATE OF DEATH

00231

00228

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> c. LENGTH OF STAY IN 1b <u>9 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 Willow Court</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u> d. STREET ADDRESS <u>111 Willow Court</u>	
3. NAME OF DECEASED (Type or print) <u>Thelma B. Day</u>		4. DATE OF DEATH Month <u>January</u> Day <u>4th</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. <u>15</u> , 19 <u>21</u>
9. AGE (In years, last birthday) <u>40</u> yrs. Months <u>4th</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Caroline Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charlie Brown</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. James B. Day 118 Willow Court # 22</u>	
17. INFORMANT <u>Mr. James B. Day 118 Willow Court # 22</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Renal failure</u> DUE TO (c) <u>Carcinoma of breast with metastases</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 weeks</u> <u>7 mos</u>	
21. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1961</u> to <u>Jan 4, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 3, 1962</u> and that death occurred at <u>home</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>J Harold Nichols</u> 22c. PHYSICIAN'S NAME (Type) <u>J HAROLD NICHOLS MD</u>		22b. DATE SIGNED <u>1-5-62</u> 22d. ADDRESS <u>7 South Lang, Dundalk, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/8/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Calvary Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>A. A. Co. Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. A. Jackson Funeral Home 916 Penna. Ave/</u>		25a. REC'D BY REGISTRAR <u>JAN 8 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

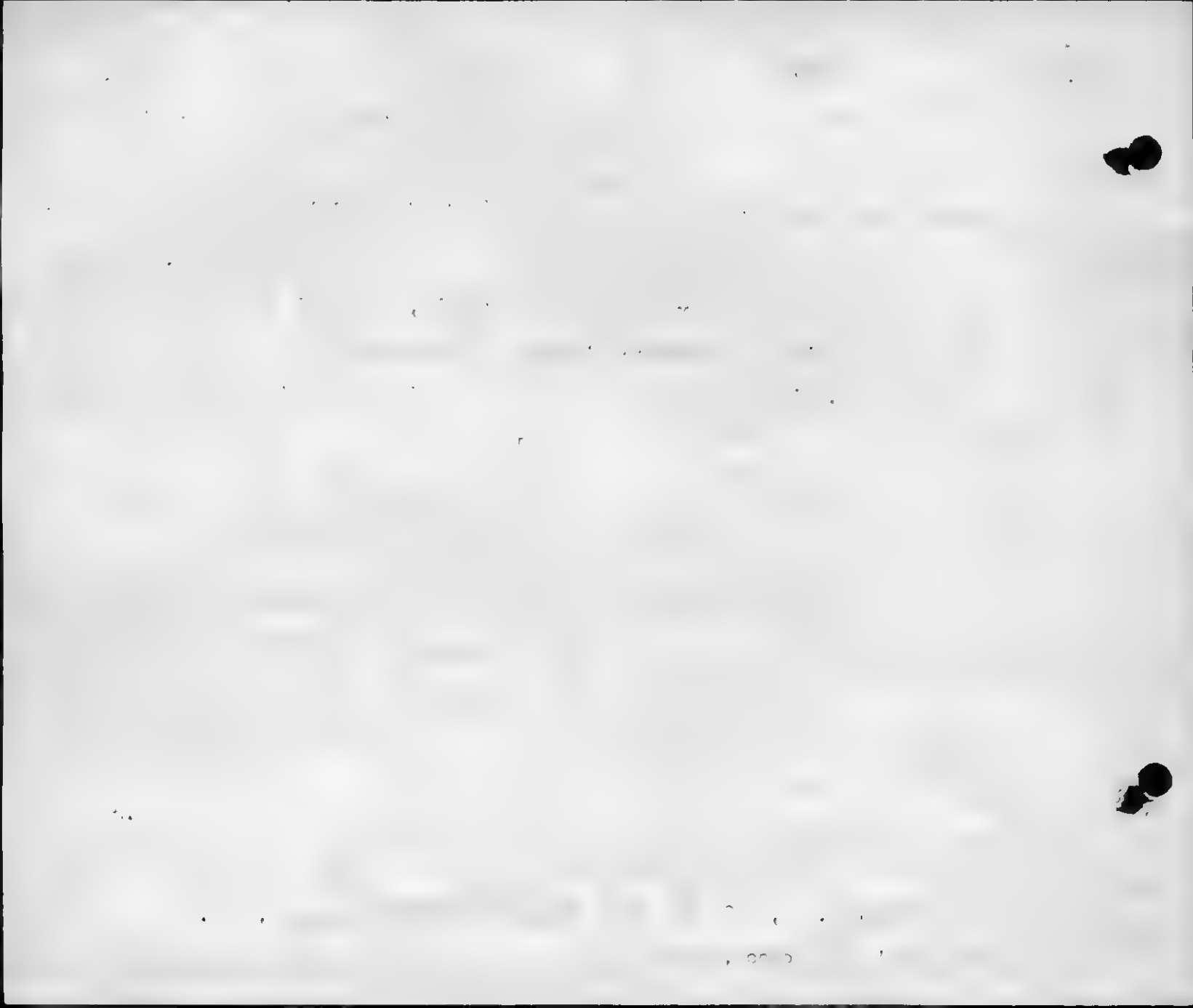


TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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3
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00232
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Convalescent Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 513 Allegheny Avenue • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARMINIUS GRAY DIXON		4. DATE OF DEATH January 11, 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1870	
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman- Retired		10b. KIND OF BUSINESS OR INDUSTRY Protestant Minister	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Dixon		14. MOTHER'S MAIDEN NAME Elsbeth Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mremia DUE TO (b) Prostatic Obstruction (Chronic) DUE TO (c) Arterio Sclerosis Renal Disease also generalized Aneurysm PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1961 to Jan 11, 1962 , that (I) (we) last saw the deceased alive on Jan 11, 1962 , and that death occurred at 2 M, from the causes and on the date stated above.			
22a. SIGNATURE Michael Byrley		22b. DATE SIGNED 1/12/62	
22c. PHYSICIAN'S NAME (Type) M Paul Byrley		22d. ADDRESS 5420 York Rd Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 15, 1962	
23c. NAME OF CEMETERY OR CREMATORY Guilford Memorial Mausoleum		23d. LOCATION (City, town or county) (State) High Point, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		25. REC'D BY REGISTRAR JAN 15 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

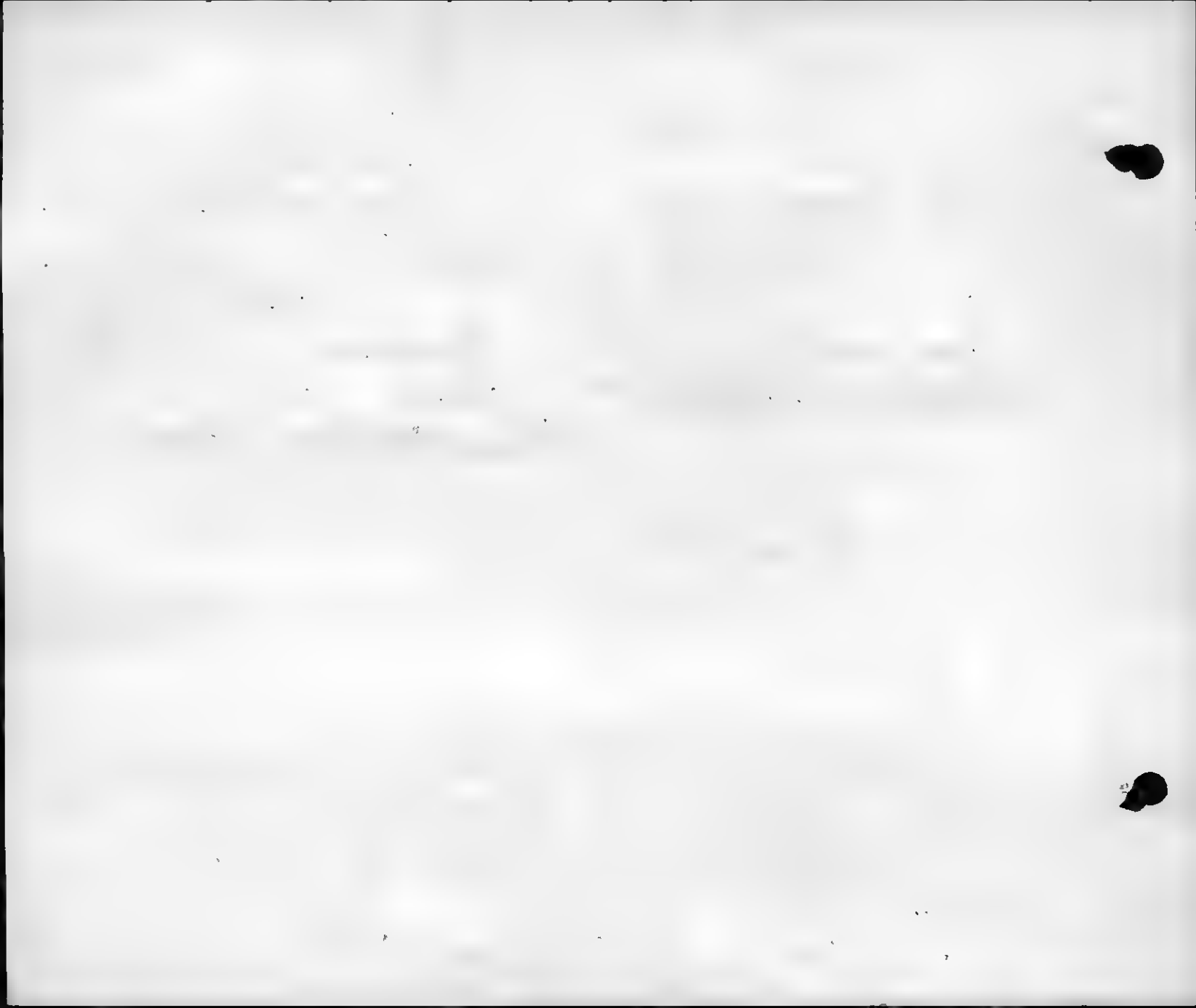
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Likesville</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Likesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1029 Flagtree Lane</i>		d. STREET ADDRESS <i>1029 Flagtree Lane</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>NETTIE</i> First <i>DOBRES</i> Middle Last		4. DATE OF DEATH Month <i>1</i> - Day <i>3</i> - Year <i>1962</i>	
5 SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
9. AGE (In years last birthday) <i>75</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Russia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13 FATHER'S NAME <i>Nathan Nelson</i>		14 MOTHER'S MAIDEN NAME <i>Leah ?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Israel Dobres</i>	
17. INFORMANT <i>same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>26 yrs</i>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <i>Feb</i> 1961 to <i>Jan 3</i> 1962, that (I) (we) last saw the deceased alive on <i>Jan 3</i> 1962, and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Joseph B Gross</i>		22b. ADDRESS <i>6911 Park Heights Cir</i>	
22c PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>1-4-62</i>	23c NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	23d LOCATION (City, town, or county) (State) <i>Balto Md</i>
24 FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		25a REGISTRY REGISTRAR DATE <i>JAN 5 1962</i>	
ADDRESS <i>2100 Entero Place</i>		25b REG STRAR'S SIGNATURE <i>Arthur S. Hume</i>	

22b. DATE SIGNED
1/4/62



may be retained in hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

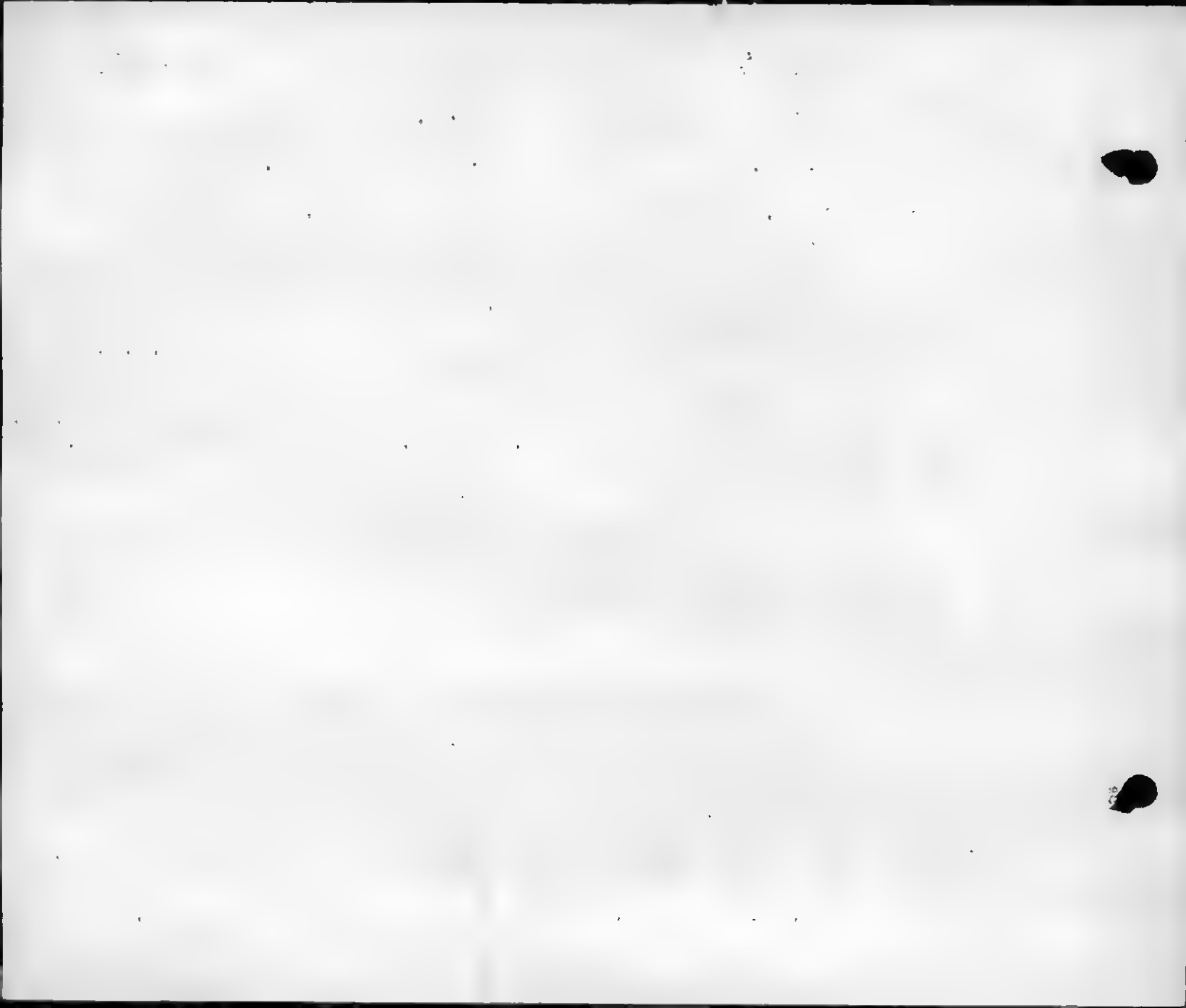
CERTIFICATE OF DEATH

00234

Item 14 File # 6405 1/22/62 iwk

00231

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville 8, Md.		c. LENGTH OF STAY IN 1b 2 weeks		2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admision a. STATE Md.		b. COUNTY Baltimore 15, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 717 Westover Rd., Pikesville						d. STREET ADDRESS 4111 Newton Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Emily Keene Egli						4. DATE OF DEATH Month Day Year January 16, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 25, 1878		9. AGE (In years last birthday) 83 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Keene						14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Pikesville 8, Md. Mrs. Lucia F. Gerwig, 717 Westover Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 5 Bronchopneumonia, terminal DUE TO (b) Carcinomatous, metastatic DUE TO (c) Carcinomatous of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								INTERVAL BETWEEN ONSET AND DEATH 72 hrs 1 yrs 1 1/2 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease & hypertension 5 yrs								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (No hospital) attended the deceased from April 12, 1957 to Jan 16, 1962 , that (I) (no) last saw the deceased alive on Jan 16, 1962 , and that death occurred at 11 P M, from the causes and on the date stated above									
22a. SIGNATURE Randolph H. Spitzberg						22b. DATE SIGNED Jan 18 1962		22c. PHYSICIAN'S NAME (Type) RANDOLPH H. SPITZBERG, M.D.	
22d. ADDRESS 3806 Fallschaff Rd. Baltimore 15, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 20, 1962		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell, Pikesville 8, Md.						25a. REC'D BY REGISTRAR DATE Jan 18 1962		25b. REGISTRAR'S SIGNATURE 84	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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00235
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00232

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wt. Wilson, Maryland</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wt. Wilson State Hospital</u>		e. STREET ADDRESS <u>4700 NAVAHO ST</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>EDWIN</u> Last <u>EHOFF</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 3, 1894</u>
9. AGE (In years lost birthday) <u>67</u> yrs		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PIPE TAPPER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>WASHINGTON</u>	
13. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>FREDERICK H. EHOFF</u>		16. MOTHER'S MAIDEN NAME <u>MINNA J. STANIG</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		18. SOCIAL SECURITY NO. <u>222-09-4676</u>	
19. INFORMANT <u>Hospital Records, Wt. Wilson State Hospital</u>		Address <u>Wt. Wilson State Hospital, Wt. Wilson, Md.</u>	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>002</u> (c) <u>002</u> DUE TO (b) <u>002</u> (c) <u>002</u>		INTERVAL BETWEEN ONSET AND DEATH <u>ONE YEAR</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
23a. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		23b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		23d. (City or town) (County) (State)	
24. I certify that (I) (this hospital) attended the deceased from <u>JAN. 2</u> , 1962, to <u>JAN. 8</u> , 1962, that (I) (we) last saw the deceased alive on <u>JAN. 8</u> , 1962, and that death occurred at <u>3:00</u> P. M. from the causes and on the date stated above.			
25a. SIGNATURE <u>W. Newcomer</u>		25b. DATE <u>1-8-62</u>	
26a. PHYSICIAN'S NAME (Type) <u>Dr. Newcomer, I.D. Superintendent</u>		26b. ADDRESS <u>Wt. Wilson State Hospital, Wt. Wilson, Md.</u>	
27a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		27b. DATE THEREOF <u>Jan 12, 1962</u>	
27c. NAME OF CEMETERY OR CREMATORIUM <u>George Washington</u>		27d. LOCATION (City, town, or county) (State) <u>Hyattsville Md.</u>	
28. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		28. ADDRESS <u>Hyattsville Md.</u>	
29a. REC'D BY REGISTRAR DATE <u>JAN 12 '62</u>		29b. REGISTRAR'S SIGNATURE <u>W. L. Newcomer</u>	



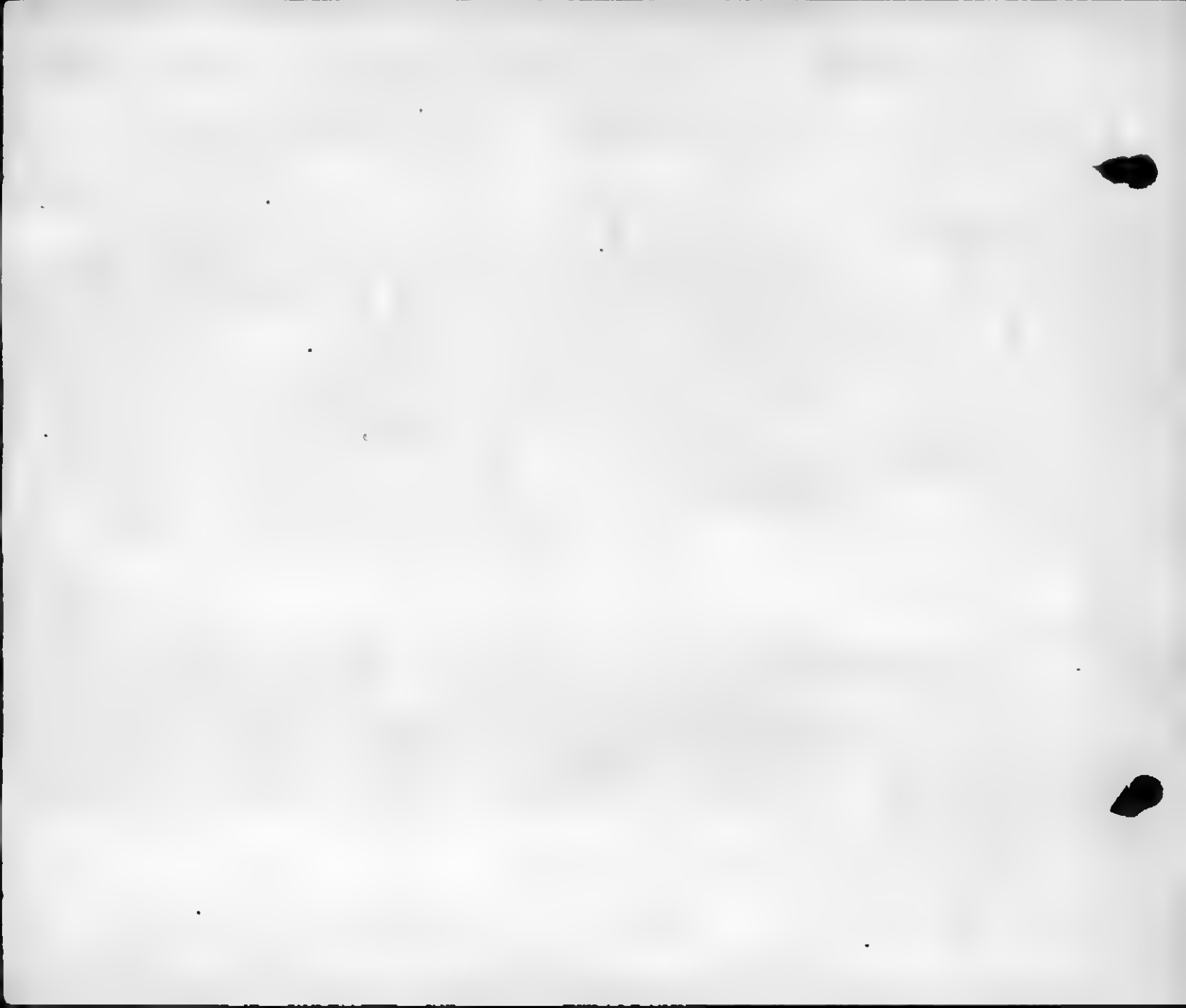
CERTIFICATE OF DEATH

Reg. Dist. No. 00236

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 2335 Milliman St.	
3. NAME OF DECEASED (Type or print) First BLANCHE Middle E. Last EICHHORN		4. DATE OF DEATH Month January Day 4, Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1873
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Heard		14. MOTHER'S MAIDEN NAME Margaret Jones	
15. WAS DECEASED EVER IN U S ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Elmer Eichhorn, 3624 Chesterfield Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 1958 to 4 January 1962 that I last saw the deceased alive on 4 January 1962 , and that death occurred at 6:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John A. Nesbitt Jr.		ADDRESS (Street, city or town, state) 1118 St Paul St Baltimore 2, Md	
PHYSICIAN'S NAME (Type) JOHN A. NESBITT JR		DATE SIGNED 1-6-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/8/62	22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24a. REC'D BY REGISTRAR JAN 9 '62	
ADDRESS 3331 Brenms Lane		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in page 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

X

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			
a. COUNTY BALTO.				a. STATE Md.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charing Mills				b. COUNTY BALTO.			
c. LENGTH OF STAY IN 1b 22 yrs				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charing Mills, Md			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Resident State Training School Baltimore State Tr. Sch.				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) CHAS.				4. DATE OF DEATH Jan 14 1962			
5. SEX Male				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Feb 11 1872			
9. AGE (In years last birthday) 69 yrs.				10. IF UNDER 1 YEAR (Months, Days, Hours, Min.) 19 62			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel T Elliott				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-10-5450			
17. INFORMANT Sally Thelma Elliott - daughter				Address Charing Mills			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH 2-4 hrs			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease				DUE TO (b) extensive lesion to heart			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)				DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Jan 14 1962				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> None			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D.D. Caples				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D.D. CAPLES				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6 Hanover Rd. Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Jan. 16, 1962			
22c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery				22d. LOCATION (City, town, or country) (State) Reisterstown, Md.			
23. FUNERAL DIRECTOR J. F. Eline & Sons				ADDRESS Reisterstown, Md.			
24a. REC'D BY REGISTRAR JAN 16 '62				24b. REGISTRAR'S SIGNATURE William S. Huns			



00238

CERTIFICATE OF DEATH

Reg. Dist. No. 00235

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harbortus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harbortus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>137 THINDEN AVE</u>		d. STREET ADDRESS <u>137 THINDEN AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>Winnifred</u> Middle <u>ELLIOTT</u> Last <u>ELLIOTT</u>		4. DATE OF DEATH Jan 27 1962	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 15 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Anthony ZNAMENACEK</u>		14. MOTHER'S MAIDEN NAME <u>ANNA POLOK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>Hanna M. Voss</u> Address <u>137 Thinden Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary tract hemorrhage</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the bladder</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1960</u> to <u>Jan. 27, 1962</u> that I last saw the deceased alive on <u>Jan. 26, 1962</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Levickas</u> M.D.		ADDRESS (Street, city or town, state) <u>5305 East Drive</u> DATE SIGNED <u>1/27/62</u>	
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		<u>Baltimore-27, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL, (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>30 Jan 1962</u>	<u>Houderman Cem</u>	<u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter T. H. H. H. H. H.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JAN 29 '62</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



b. COUNTY

~~XXXXXXXXXX~~ Baltimore

821 N. Streeper St.

• IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Last	4. DATE OF DEATH	Month	Day	Year
		January	25	19 62

9. AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS)

74	Months	Days	Hours	Min.
----	--------	------	-------	------

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

Rose Ann Carney

INFORMANT	Address
Charles E. Ernst, son, above	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

1 copy

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part I of item 1B.)

{State}

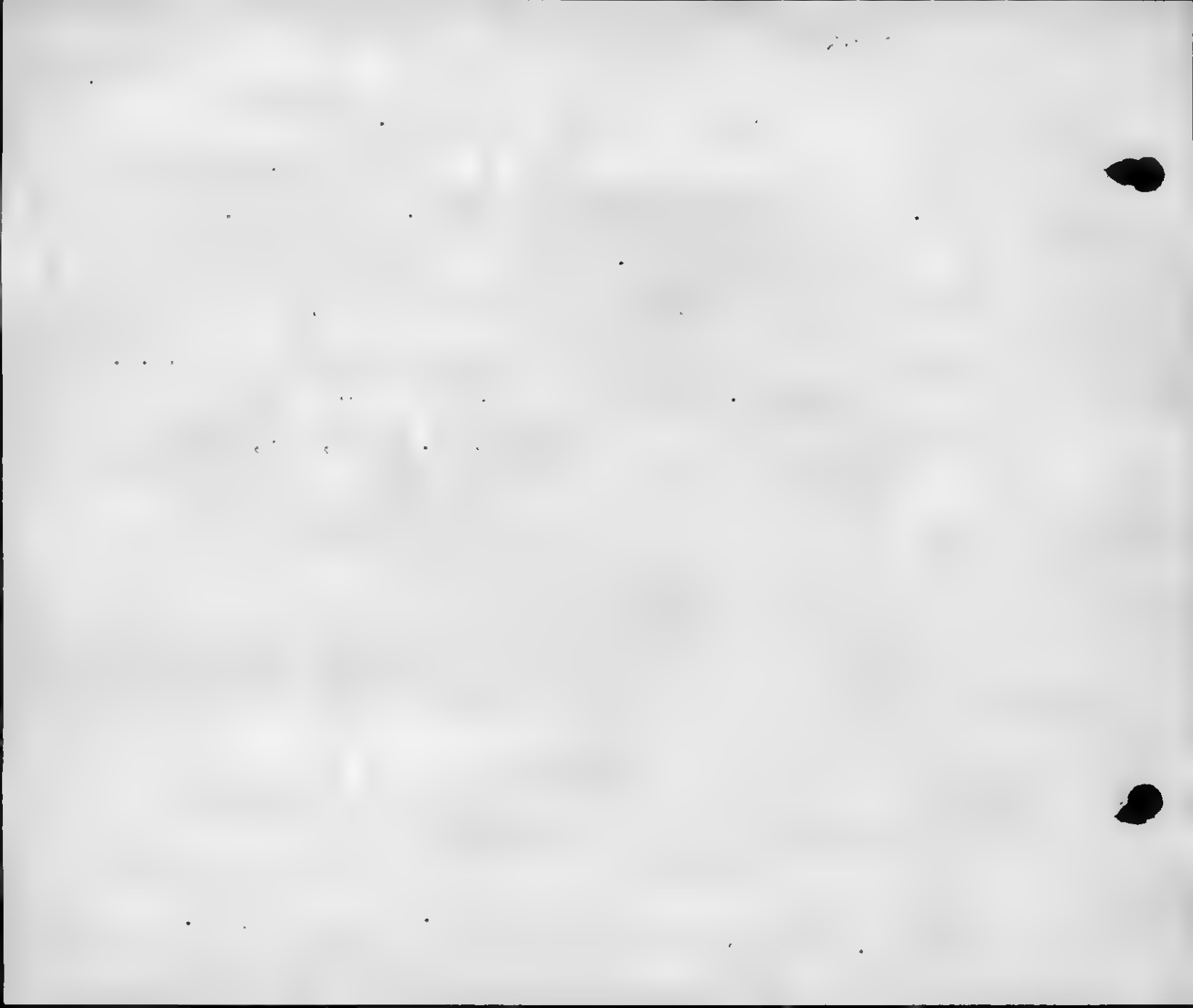
21. I **certify** that (I) (this hospital) attended the deceased from .. 10-2 .., 1961, to .. 1-25 .., 1962. That (I) (we) last saw the deceased alive on .. 1-25 .., 1962 and that death occurred at 7 AM, from the causes and on the date stated above.

22b. DATE
SIGNED
1-26-62

(State)

25b. REGISTRAR'S SIGNATURE

William S. Knaus



hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-12-62 File 306

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00240 111237

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL MARIOTTSTVILLE
c. LENGTH OF STAY IN life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reisberg Lane

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL MARIOTTSTVILLE
d. STREET ADDRESS Reisberg Lane

3. NAME OF DECEASED (Type or print) HILDA Elizabeth EWARTOSKI
4. SEX Female 5. COLOR OR RACE White 6. MARRIED ☐ NEVER MARRIED ☒ 7. DATE OF BIRTH June 11, 1904 8. AGE (In years last birthday) 57 yrs 9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker 10b. KIND OF BUSINESS OR INDUSTRY HUTZLER BROS. 11. BIRTHPLACE (County & State, or foreign country) M.D. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HERMAN EWARTOSKI 14. MOTHER'S MAIDEN NAME CARRIE L. BEDECKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. 214-01-1290 17. INFORMANT Mrs. CARRIE L. EWARTOSKI - ABOVE Address AS.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial thrombosis
19 9X DUE TO Carcinomatosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)
(PARTIAL SITE NOT DETERMINED)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).
INTERVAL BETWEEN ONSET AND DEATH 5 yrs

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/11/1962 to 1/12/1962, that (I) (we) last saw the deceased alive on 1/12/1962, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE Wm. E. Martin 22b. DATE SIGNED 1/15/62
22c. PHYSICIAN'S NAME (Type) W.M. E. MARTIN M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22d. ADDRESS Farmersville, Md.

23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL 23b. DATE THEREOF 1-15-62 23c. NAME OF CEMETERY OR CREMATORIUM WARDS Chapel Cemetery 23d. LOCATION (City, town or county) (State) BALTIMORE Co., MD.

24. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight ADDRESS Hydenville, Md. 25a. REC'D BY REGISTRAR C. J. H. H. 25b. REGISTRAR'S SIGNATURE C. J. H. H. DATE JAN 22 '62



00241

CERTIFICATE OF DEATH

Reg. Dist. No. 111238

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Linden Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Bruno Fairley</u>		4. DATE OF DEATH Month Day Year <u>January 31 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1869</u>
9. AGE (In years last birthday) <u>92</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - R. Dickey Drug Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CHIEF OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas Fairley</u>		14. MOTHER'S MAIDEN NAME <u>Rose Helter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <u>218-07-7564A</u>	
17. INFORMANT <u>Mrs Louise Faustle - 11 Linden Terrace</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>+50.0</u> DUE TO <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1960</u> to <u>Jan 31 1962</u> that I last saw the deceased alive on <u>Jan 26 1962</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul H. Royse</u> M.D.		ADDRESS (Street, city or town, state) <u>1403 Foley Lane Pikesville 8 Md.</u> DATE SIGNED <u>Jan 31, 62</u>	
PHYSICIAN'S NAME (Type) <u>Paul H. Royse MD</u>		<u>Pikesville 8 Md.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-3-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville, Md.</u>		24a. RECEIVED BY REGISTRAR <u>11-11-62</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>11-11-62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

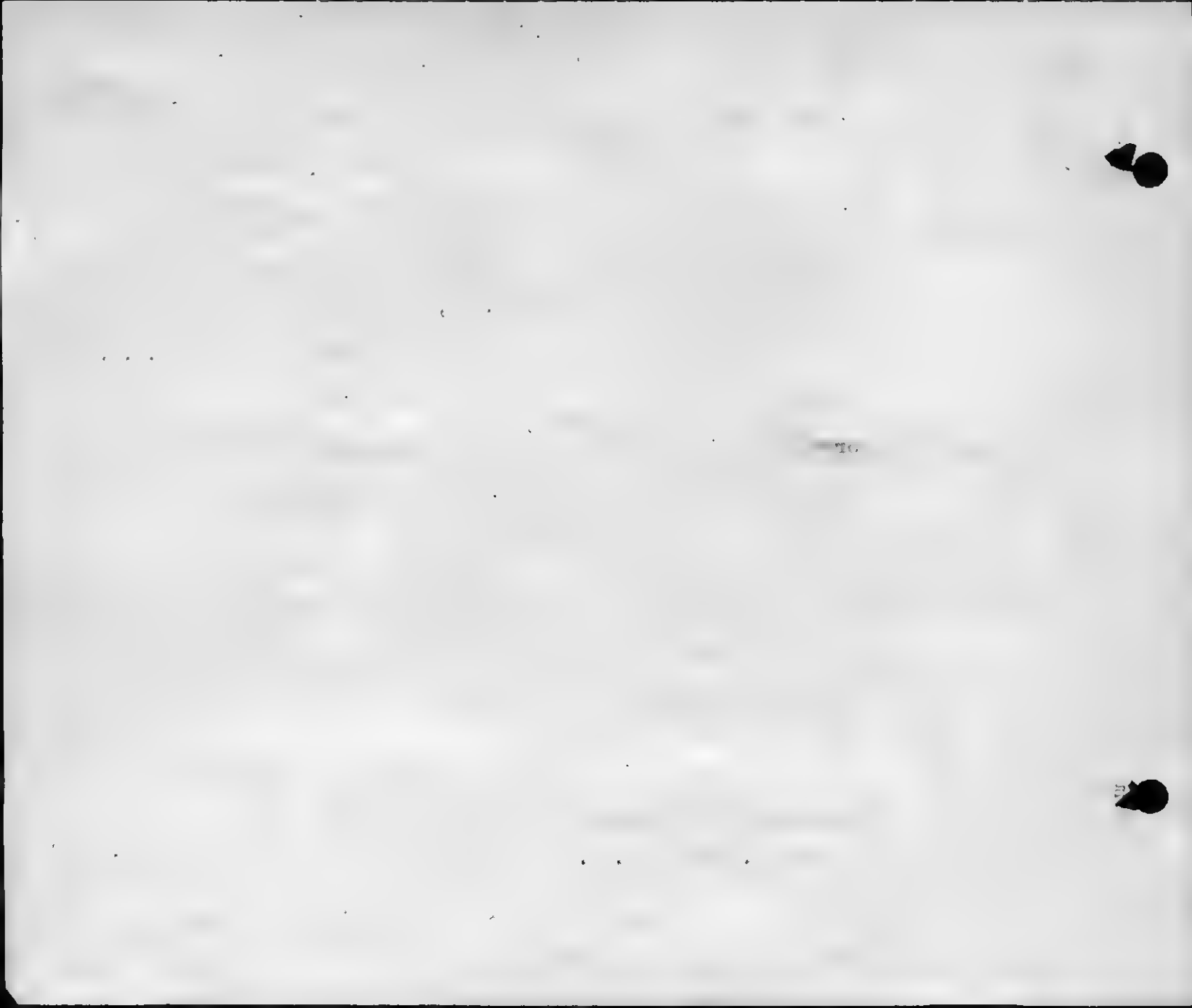


1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) College Park, Maryland d. STREET ADDRESS 23 Fifth Street - Cherry Hill Trailer Park	
3. NAME OF DECEASED (Type or print) STEVE		4. DATE OF DEATH Last FARKAS Month January Day 7 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1921
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) glazier		9. AGE (In years last birthday) 40 IF UNDER 1 YEAR Months Days Hours Min.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Paul Farkas		14. MOTHER'S MAIDEN NAME Suzie Benka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 228-18-1286	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty change of liver (severe) with early Laennec's cirrhosis DUE TO Conditions, if any, which gave rise to immediate cause (b) 5211 (c) Laennec's cirrhosis DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) Removal		22b. DATE THEREOF 1-10-62	
22c. NAME OF CEMETERY OR CREMATORY Washington Memorial Park		22d. LOCATION (City, town, or country) Richmond, Virginia	
23. FUNERAL DIRECTOR Wm. J. ...		24a. REC'D BY REGISTRAR JAN 11 '62	
24b. REGISTRAR'S SIGNATURE ...		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, it should be executed within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



VR A15 (4)
15M 9/60

~~Item 23b Film 0305 1/19/62~~

Robert L. Kline



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate has been signed by the attending physician and completely filled by the funeral director. Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

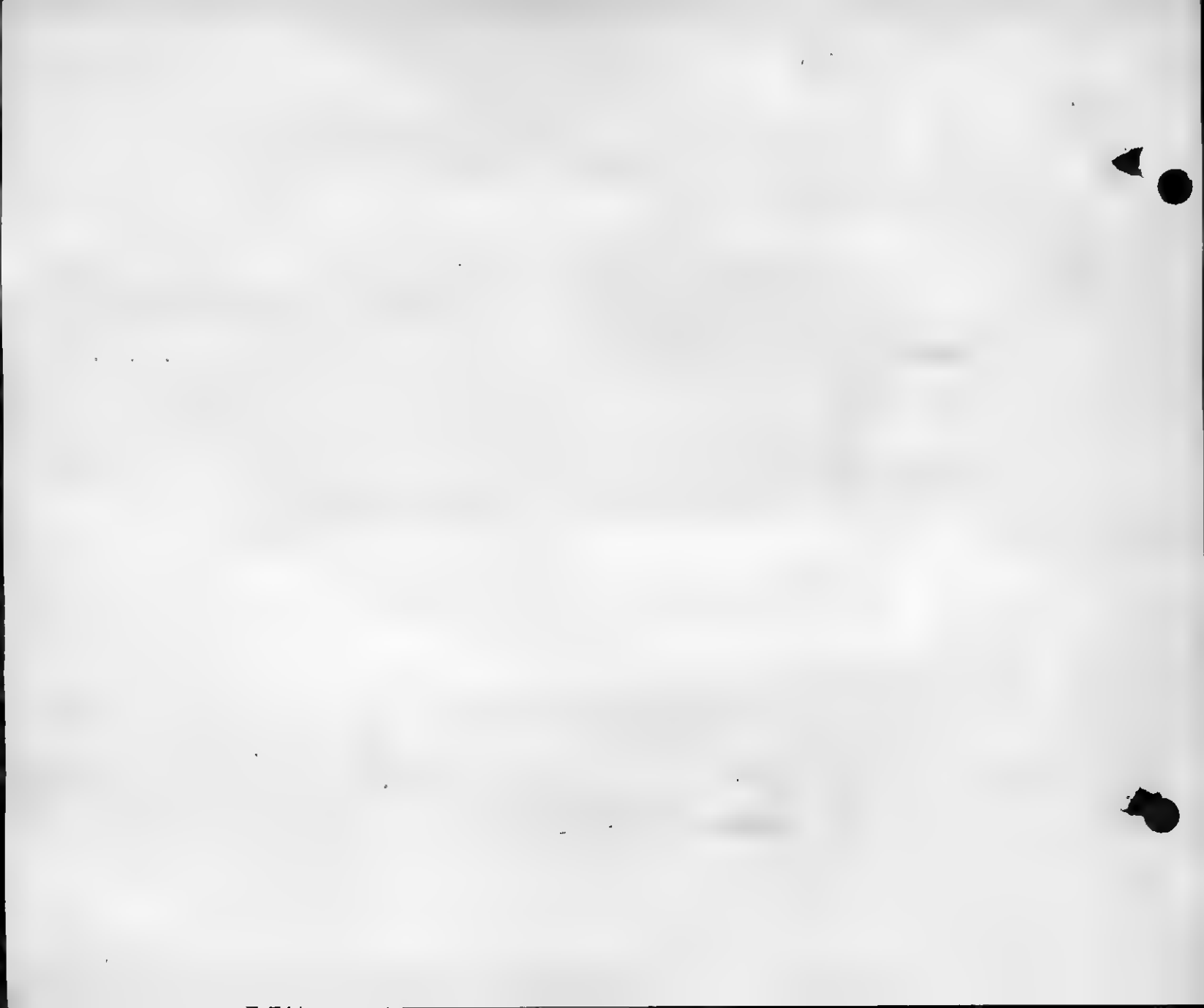
00244

CERTIFICATE OF DEATH

Item 9 Film 6305 1/3/62 mh

00241

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mth26dys	
2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. STREET ADDRESS 212 Altamont Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) Elmer		4. DATE OF DEATH Month January Day 3 Year 1962		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1893	
9. AGE (In yr last birth) 67 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel mill		11. BIRTHPLACE (Country & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME James Fields		14. MOTHER'S MAIDEN NAME Virginia HENNEBERGER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 215-01-5202		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (b) +22.1 (c) DUE TO (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (this hospital) attended the deceased from March 29, 1961 , to Jan. 3, 1962 , that (we) last saw the deceased alive on Jan. 3, 1962 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Sulla Wachsler		22b. DATE SIGNED 1-3-62		22c. PHYSICIAN'S NAME (Type) Sulla Wachsler, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL		22e. LOCATION (City, town or county) Catonsville 28, Maryland		22f. (State) Ind.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-6-62		23c. NAME OF CEMETERY OR CREMATORY London Park Cem.	
24. FUNERAL DIRECTOR'S SIGNATURE Foray - Brown F. H. Catonsville, Md.		24a. ADDRESS 7111		25a. REC'D BY REGISTRAR JAN 4 '62	
25b. REGISTRAR'S SIGNATURE C. S. H.		25c. DATE JAN 4 '62			



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00245
00242

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
c. LENGTH OF STAY IN life <u>Life</u>		d. STREET ADDRESS <u>7817 Bagley Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7817 Bagley Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Elizabeth</u> Last <u>Fischer</u>		4. DATE OF DEATH Month <u>1</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-1867</u>
9. AGE (In years last birthday) <u>94</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Robert Fischer</u>		Address <u>7817 Bagley Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>Secondary</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia, severe.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>20 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. [City or town] (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1961</u> to <u>Jan 1962</u> that (I) (last) saw the deceased alive on <u>22 Dec 1961</u> and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph F. Li Pira</u>		22b. DATE SIGNED <u>1-3-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. Li Pira</u>		22d. ADDRESS <u>84 Voloch Haven Blvd. Balt'y</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-4-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lasson Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 5 1962</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Thayer</u>		DATE	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
00246			
00243			
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if not in one; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8151 Loch Raven Blvd.		d. STREET ADDRESS 8151 Loch Raven Boulevard	
3. NAME OF DECEASED (Type or print) Emma Charlotte Fisher		4. DATE OF DEATH January 5 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 19, 1867
9. AGE (In years last birthday) 94 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Homemaker	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Ellis		14. MOTHER'S MAIDEN NAME Sophia ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Elmer H. Bing- 8151 Loch Raven Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE Cornary Sclerosis Arterio Sclerosis heart disease General Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a). INTERVAL BETWEEN ONSET AND DEATH 9 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1953 to Jan 5, 1962		20f. (City or town) (County) (State) Baltimore, Maryland	
21. I certify that (I) (this hospital) attended the deceased from 1953 to Jan 5, 1962 , that (I) (we) last saw the deceased alive on Jan 5, 1962 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Lee K Fargo		22b. DATE SIGNED Jan 5 1962	
22c. PHYSICIAN'S NAME (Type) LEE K FARGO M.D.		22d. ADDRESS 8155 LOCH RAVEN BLVD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-62	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. [Signature]		25a. REC'D BY REGISTRAR DATE JAN 8 '62	
25b. REGISTRAR'S SIGNATURE Chas E. Kiana			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

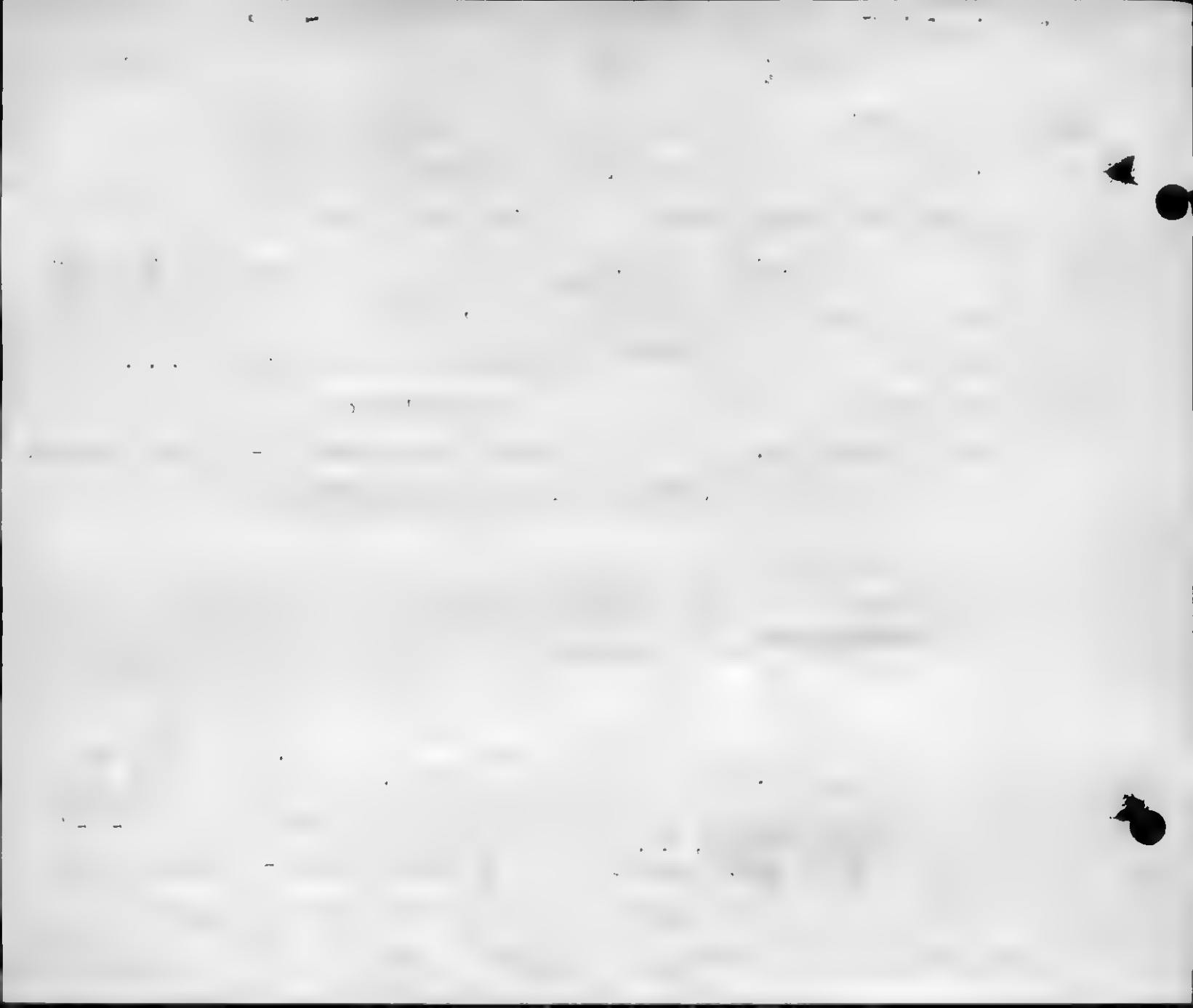
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00247

00244

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 576 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Julia H. FISHER		4. DATE OF DEATH January 18 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing	
13. FATHER'S NAME John Fisher		14. MOTHER'S MAIDEN NAME Bridget O'Boyle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes Spanish-Amer.		16. SOCIAL SECURITY NO. Clin Rec VAH Baltimore Md - Ft Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (a), stating the underlying cause last. (c) 10 Years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 21 1960 to Jan. 18 1962 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Jan. 18 1962 , and that death occurred at 9:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE Irving Freeman		22b. DATE SIGNED 1-19-62	
22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Chief, Medical Service		22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/22/1962	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny Inc. 1600 Hollins St BALTO. 23-Md		25a. REC'D BY REGISTRAR JAN 24 '62	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00245

00248

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home In The Pines</u>		d. STREET ADDRESS <u>141 S. Monastery Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MICHAEL P. FLAHERTY</u>		4. DATE OF DEATH Month Day Year <u>JAN. 29 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1871</u>
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>MR. MORTON L. FLAHERTY</u>		Address <u>141 S. Monastery Ave.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL LASCAUR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ATHEROSCLEROSIS</u> DUE TO (c)		<u>7 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>July 1, 1953</u> , to <u>JAN 29, 1962</u> , that I last saw the deceased alive on <u>JAN 26, 1962</u> , and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>HERBERT H. JAMES, M.D.</u> 4804 FREDERICK AVE. BALTIMORE 29, MD — MF 43655	ADDRESS (Street, city or town, state) <u>4804 Frederick Ave.</u> DATE SIGNED <u>1/29/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 1, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM. BALTO. MD.</u>
22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. TRUMAN Schwab</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '62</u>
ADDRESS <u>3512 Fred. Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Carline E. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained in the hospital or attending physician's office for 10 days after the death. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

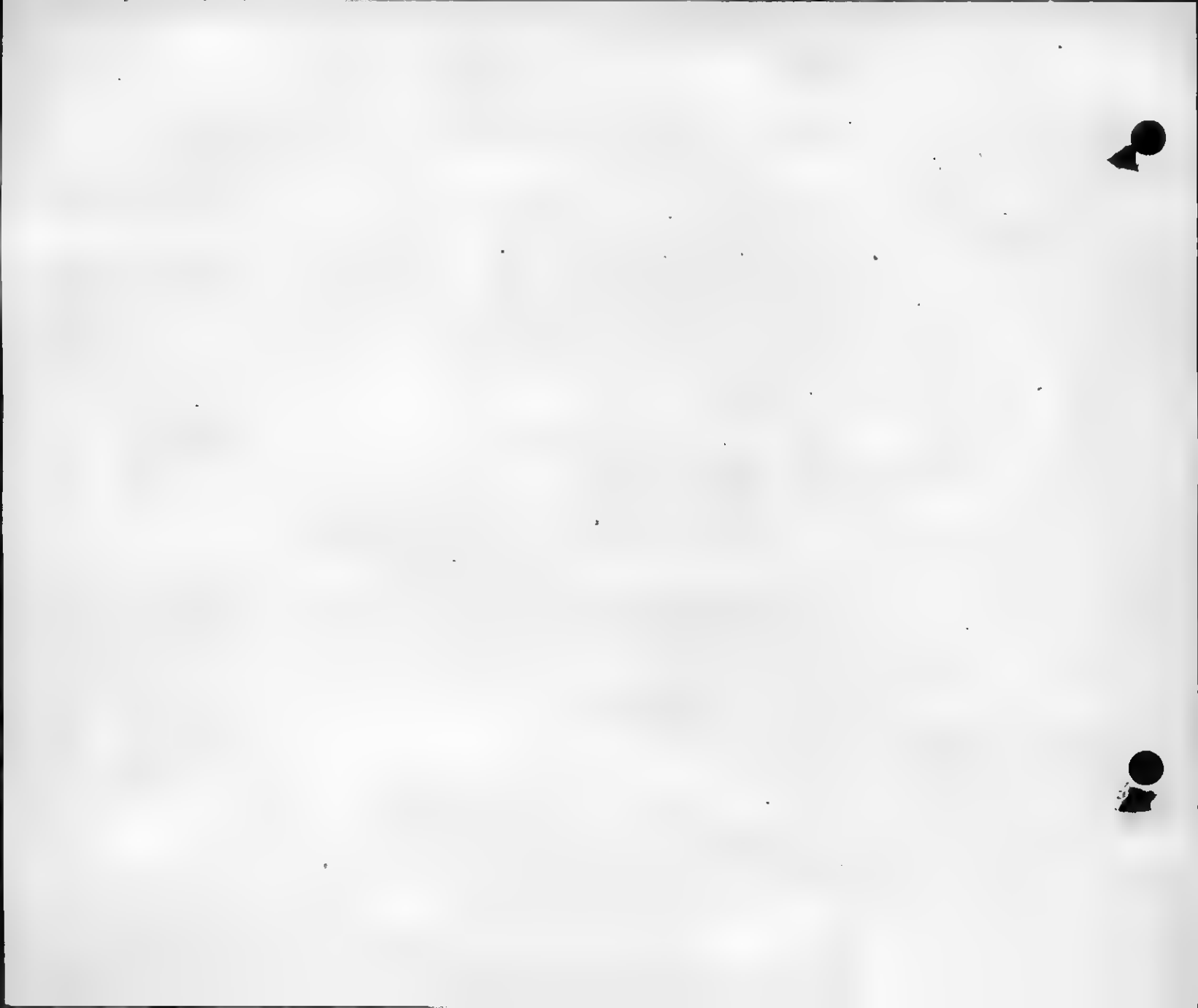
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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00249

00246

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPERCO				c. LENGTH OF STAY IN 1b 5 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GORSUCH MILL ROAD				d. STREET ADDRESS GORSUCH MILL ROAD			
3. NAME OF DECEASED (Type or print) EDNA EPPLEY FLORA				4. DATE OF DEATH JAN. 18 1962			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APR 15-1883	9. AGE (In years lost birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ALTERATIONS FOR DEPT. STORE				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME JOHN BIKLER EPPLEY				14. MOTHER'S MAIDEN NAME MARTHA CARBER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO UNKNOWN		17. INFORMANT MRS FREDERICK HEITER Address UPPERCO MD	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1. Trauma of obstruction DUE TO Carcinoma of thyroid Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 yrs DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Has had tracheotomy tube for 4 yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from Sept. 1957 to Jan. 18 1962 that (I) (we) last saw the deceased alive on Jan. 17 1962 and that death occurred at 9 P.M. from the causes and on the date stated above			
22a. SIGNATURE M.C. Porterfield M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-19-62	
22c. PHYSICIAN'S NAME (Type) M.C. Porterfield				22d. ADDRESS Hampstead, Md.			
23a. BURIAL, CREMATION, REMOVAL, (Specify) BURIAL		23b. DATE THEREOF JAN 21-62		23c. NAME OF CEMETERY OR CREMATORY MT VIEW CEM.		23d. LOCATION (City, town, or county) (State) UNION BRIDGE MD	
24. FUNERAL DIRECTOR'S SIGNATURE O. D. Harkins ADDRESS UNION BRIDGE MD				25a. REC'D BY REGISTRAR JAN 23 '62		25b. REGISTRAR'S SIGNATURE Annal B. Funder	

MEDICAL CERTIFICATION ON



00250

CERTIFICATE OF DEATH

Reg. Dist. No. 00247

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3413 PUTTY HILL AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MYRILE E FOUNDS</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 10 1905</u>
9. AGE (In years lost birth day) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY C BROWN</u>		14. MOTHER'S MAIDEN NAME <u>NETTIE URICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Mrs. Joseph Zingery Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420 - 1</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> (c) <u>Age + Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Severe bout of Adrenal insufficiency 18 mos ago</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>5+ yr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 14 1958</u> to <u>Jan 14 1962</u> that I last saw the deceased alive on <u>Jan 14 1962</u> and that death occurred at <u>5 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9005 HARTFORD RD BALTIMORE MD</u> DATE SIGNED <u>1/16/62</u> ACTUAL SIGNATURE <u>Frank T. Kasik, Jr. M.D.</u> PHYSICIAN'S NAME (Type) <u>DR. FRANK T. KASIK, JR.</u> <u>BALTIMORE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/18/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS + Son</u> ADDRESS <u>8802 HARTFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 18 62</u> 24b. REGISTRAR'S SIGNATURE <u>James S. Evans</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00251

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

001248

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if inst lnt on, Residence before adm ssion) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 304 Townsend Road		d. STREET ADDRESS 304 Townsend Road	
3. NAME OF DECEASED (Type or print) KATHERINE FRITZ (SCHADY)		4. DATE OF DEATH Month Jan. Day 10, Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Helmar		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Margaret Ernest 328 Nicholson Rd. Balto. 21, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 A-S-C-V Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/62	
22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR James E. Bruzdinski		24a. REC'D BY REGISTRAR JAN 11 '62	
ADDRESS 1407 Eastern Ave.		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

DATE SIGNED
1/10/62



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00252

CERTIFICATE OF DEATH

00249

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY N 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1256 Elm Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1256 Elm Road	
3. NAME OF DECEASED (Type or print) Ida May 5. SEX female 6. COLOR OR RACE white 7. MARRIAGE STATUS NEVER MARRIED 8. DATE OF BIRTH Jan. 10, 1878 9. AGE (In years last birthday) 83 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.		4. DATE OF DEATH Jan. 10, 1962 13. FATHER'S NAME Zachari Wingate 14. MOTHER'S MAIDEN NAME Rebecca Scheckels 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT George Gabe 1256 Elm Road Baltimore 27, Md. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (e) Uremia (b) DUE TO generalized arteriosclerosis (c) DUE TO securility PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from April 4, 1950, to Jan 10, 1962, that (I) (we) last saw the deceased alive on Jan 10, 1962, and that death occurred at 11:15 A.M. from the causes and on the date stated above. 22a. SIGNATURE A. B. Daugharthy 22c. PHYSICIAN'S NAME (Type) A. B. Daugharthy, M. D. 22d. ADDRESS 1264 Francis Avenue, Halethorpe 27, Md. 22b. DATE SIGNED Jan 15 '62 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/13/62 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland 24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue #29 25a. REC'D BY REGISTRAR Jan 15 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Harris	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00250

00253

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KEISLERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BENT NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MRS BARBARA TANZER MILLER</u>				4. DATE OF DEATH <u>JAN. 22 1962</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 16 - 1870</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md</u>	
13. FATHER'S NAME <u>Z. KOPRIVA</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>MRS ANNA MARIE MILLER</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>422</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC C.V. DISEASE</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>YEARS</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>JANUARY 5, 1962</u> , to <u>JANUARY 22, 1962</u> , that I last saw the deceased alive on <u>JANUARY 21, 1962</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martha E. Strick</u>				ADDRESS (Street, city or town, state) <u>48 MAIN ST. KEISLERSTOWN, MD</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>1/22/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-24-62</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Harford</u>		22d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. V. 305</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 24 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician's office. This certificate has been signed by the attending physician and completely filled in by the registrar, director, or funeral director. For this certificate to be used for the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00254

00254

1. PLACE OF DEATH

a. COUNTY

Balto.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middle River

c. LENGTH OF STAY IN

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

Md.

Balto.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Middle River

d. STREET ADDRESS

P.O. Box 5033 Balto. 20 Md. P.O. Box 5033

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

JAMES FRANCIS

GARRETT

4. DATE OF DEATH

Jan. 9 1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

8-23-12

9. AGE (in years last birthday)

49 yrs

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cincher Products

10b. KIND OF BUSINESS OR INDUSTRY

Balto.

11. BIRTHPLACE (County & State or foreign country)

Balto.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Garrett

14. MOTHER'S MAIDEN NAME

Sophia Oles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

215-03-8082

17. INFORMANT

John Garrett 113 Margaret Ave. (S)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Conditions, if which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

*Acute myocardial infarction
Arteriosclerotic coronary vascular disease 5 yrs*

INTERVAL BETWEEN ONSET AND DEATH

Immed.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. City or town

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from *Dec. 1961*, to *Jan. 9 1962*, that (I) (we) last saw the deceased alive on *Jan 9 1962*, and that death occurred at *3 A.M.* from the causes and on the date stated above.

22a. SIGNATURE

Louis Semenov

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

1/9/62

22c. PHYSICIAN'S NAME (Type)

LOUIS SEMENOFF

22d. ADDRESS

2108 CREMS RD BALTO 20, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

1-12-62

23c. NAME OF CEMETERY OR CREMATORY

Oak Lawn

23d. LOCATION (City, town or county)

Balto Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE

John D. Connelly

ADDRESS

418 Eastern Blvd.

25a. REC'D BY REGISTRAR

DATE JAN 11 '62

25b. REGISTRAR'S SIGNATURE

Carroll S. Thomas

TO HOSPITAL: The law requires that the death certificate be completed within 48 hours after death. It must be signed by the attending physician and completely filled out. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



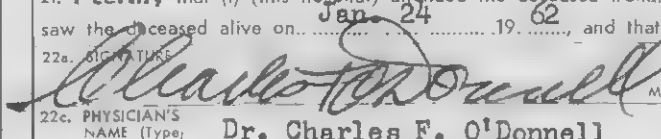
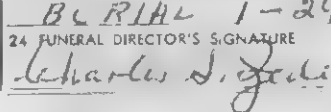
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

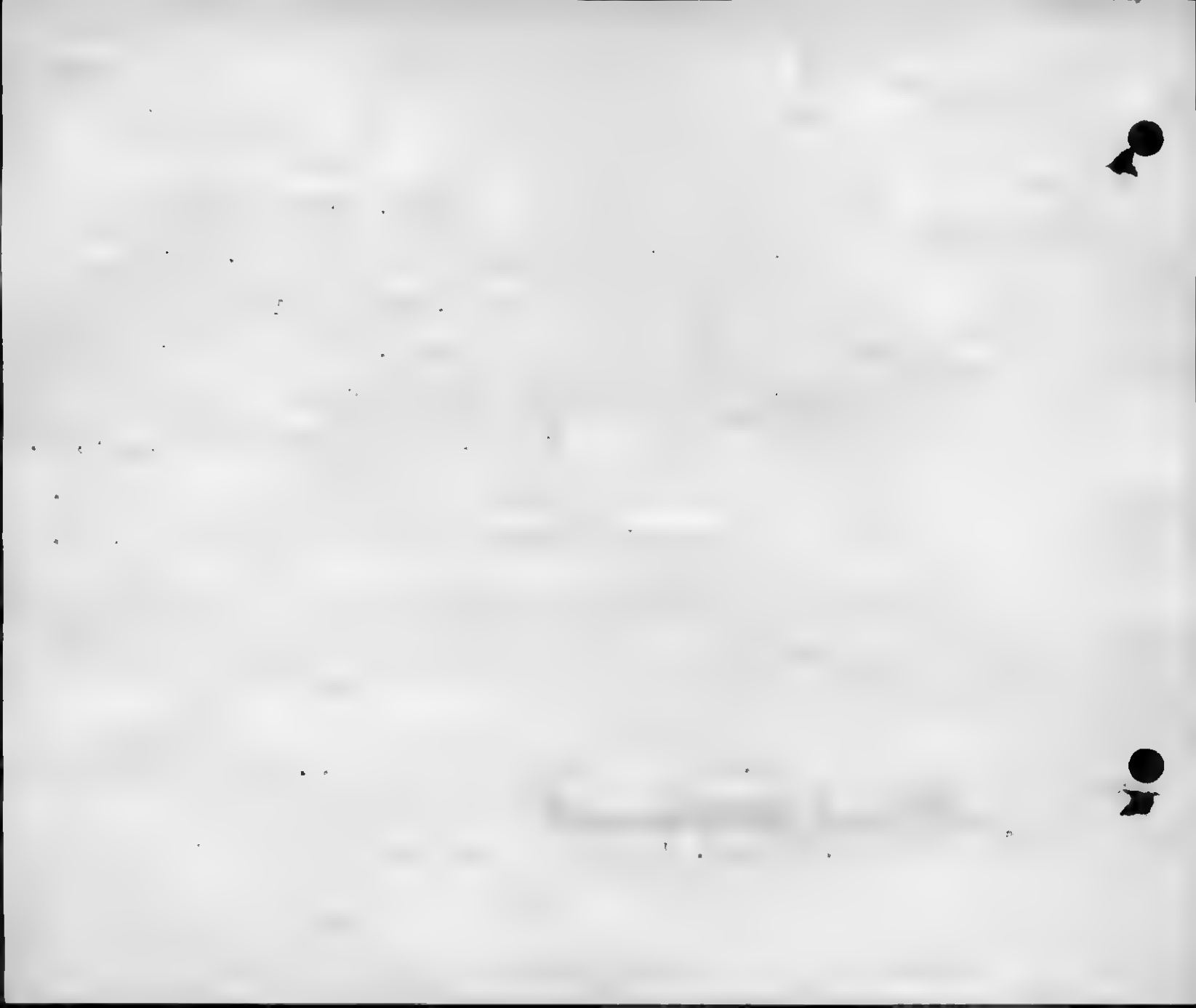
00255

00252

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Villa Maria -- Notch Cliff				d. STREET ADDRESS Glenarm, Maryland			
3. NAME OF DECEASED First Middle Last Sister Mary Gabriel (Gengler)				4. DATE OF DEATH Month Day Year Jan. 27 19 62			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1880	
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gabriel Gengler				14. MOTHER'S MAIDEN NAME Mary Berbrich			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Sister M. Henrica				Address Villa Maria Glenarm, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450X DUE TO Acute decomposition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Generalized Asterio-sclerosis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1955 to January 1962 that (I) (we) last saw the deceased alive on Jan 24 1962 and that death occurred at 11:55 a.m. from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED May 1962			
22c. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell				22d. ADDRESS 7501 York Road Towson 4, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-24-62		23c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		23d. LOCATION (City, town or county) (State) NOTCH CLIFF NR TOWSON, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE 				25a. REC'D BY REGISTRAR Charles J. Jones			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00256

00253

1. PLACE OF DEATH

a. COUNTY

BALTO.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ESSEX

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

MD.

b. COUNTY

BALTO.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ESSEX

d. STREET ADDRESS

64 BERKSHIRE RD.

a. US RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED

(Type or print)

FREDERICK

First

L. GERLACH

Middle

Last

4. DATE OF DEATH

Month

Day

Year

JAN. 12- 1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

NOV. 29-1900

9. AGE (In years last birthday)

61 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

M'n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Gen. Janitor

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

BALTO. MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

FRANKLIN L. GERLACH

14. MOTHER'S MAIDEN NAME

MARY HOHN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

THERESA (WIFE) SAME AS ABOVE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)

Carcinoma of liver lung metastasis

INTERVAL BETWEEN ONSET AND DEATH

9-18-61

12-15-61

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

21d. INJURY OCCURRED While at work ☐ Not While at work ☐

21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(Country)

(State)

21. I certify that (I) (th's hospital) attended the deceased from Sept 18, 1961 to Jan 12, 1962 that (I) (we) last saw the deceased alive on Jan 10, 1962 and that death occurred at 9 P.M. from the causes and on the date stated above.

22a. SIGNATURE

David H. Burns

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

115 O. Cager St. 1-15-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

1-16-1962

23c. NAME OF CEMETERY OR CREMATORY

SACRED HEART CEM. BALTO CO., MD.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

John J. Connolly-416 Eastern Blvd.

ADDRESS

25a. REC'D BY REGISTRAR

DATE JAN 17 '62

25b. REGISTRAR'S SIGNATURE

Charles E. Hume

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00257

00254

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 c. LENGTH OF STAY IN IL d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Caton Ridge Nursing Home, 329 Harlem Lane		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY [REDACTED] c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 d. STREET ADDRESS 107 South Chapel Street	
3. NAME OF DECEASED (Type or print) VITOL First Middle Last 5. SEX male 6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH December 8, 1882 9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR: Months Days Hours Min. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser 10b. KIND OF BUSINESS OR INDUSTRY Tailoring	
11. BIRTHPLACE County & State, or foreign country Poland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown 14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give order and date of service) no 16. SOCIAL SECURITY NO. 213-10-0346 17. INFORMANT Address Caton Ridge Nursing Home, 329 Harlem Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of prostate DUE TO (b) plasma as a result of (a) DUE TO (c) [REDACTED] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Heavy death - malnutrition 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 6/18, 1962, to 1/28, 1962 , that (I) (we) last saw the deceased alive on 1/28, 1962 , and that death occurred at 3:15 AM , from the causes and on the date stated above. 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Cliff Ratliff, Jr., M.D. 22b. DATE SIGNED 1/30/62 22d. ADDRESS 4605 Edmondson Avenue, Zone 29 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 2-2-62 23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery 23d. LOCATION (City, town or county) (State) Baltimore 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook, Inc., 1217 St. Paul Street, Zone 2 25a. REC'D BY REGISTRAR DATE FEB 2 '62 25b. REGISTRAR'S SIGNATURE Walter S. Thomas			

TO HOSPITAL: This certificate is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
 TO HOSPITAL: This certificate is to be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

2

M

X

I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00258

00255

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY +			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Randallstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box #5 Dogwood Road				1. d. STREET ADDRESS Box #5 Dogwood Road			
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Good				4. DATE OF DEATH Month January Day 18 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1883	
9. AGE (In years last birthday) 78 yrs		10. IF UNDER 1 YEAR Months 5 Days 18 Hours 15 Min.		11. IF UNDER 24 HRS Months 5 Days 18 Hours 15 Min.		12. IF UNDER 24 HRS Months 5 Days 18 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Wilbur Fritzinger			
14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. Mrs. John Bonsall - Dogwood Rd. - Randallstown				17. INFORMANT Mrs. John Bonsall - Dogwood Rd. - Randallstown			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Approximate C.V. Disease & Hardened Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 YEARS (c) INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. 19 Day. 19 Year. 19 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT 10, 1954 to JAN 18, 1962 , that (I) (we) last saw the deceased alive on JAN 18, 1962 and that death occurred at 5 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Edwin L. Pierpont				22b. DATE 1/19/62			
22c. PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.				22d. ADDRESS 2704 LIBERTY RD., BALTO 7, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/20/62		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Edmund J. Chmura				25a. REC'D BY REGISTRAR JAN 24 '62			
25b. REGISTRAR'S SIGNATURE Edmund J. Chmura				25c. ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.			



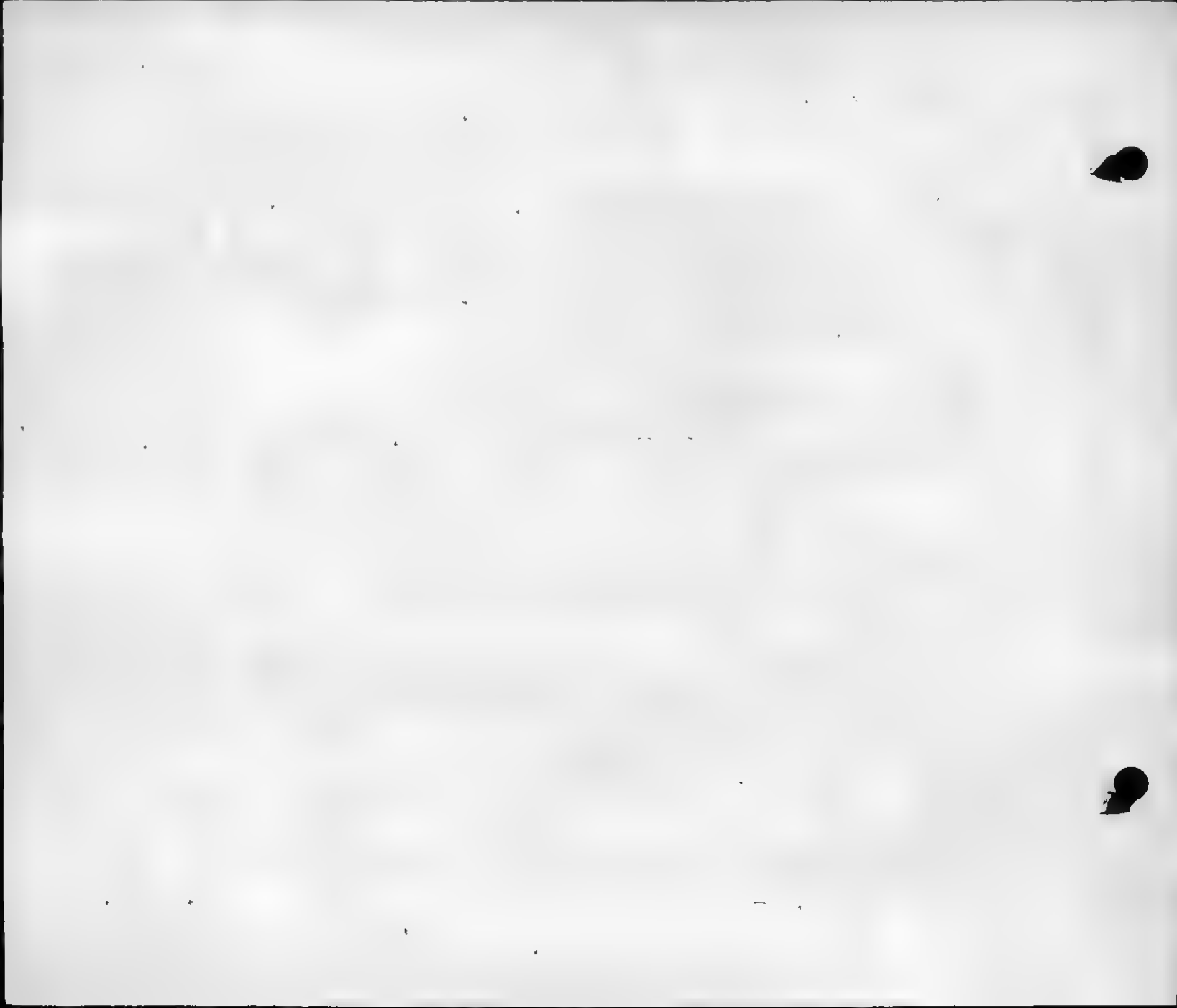
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00256

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home (98 Smithwood				d. STREET ADDRESS A. 3810 Claremont St.			
3. NAME OF DECEASED (Type or print) First Luigi Middle Graziaplana Last Graziaplana				4. DATE OF DEATH Month January Day 18 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Novem. 15 1879	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 2 Days 2	IF UNDER 24 HRS Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor retired		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co (Italy)		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Giuseppe Graziaplana				14. MOTHER'S MAIDEN NAME Lucia ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO 213-09-0864		17. INFORMANT (Frederick C. Graziaplana 103 S. Robinson St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease DUE TO Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arthritis DUE TO Rheumatoid (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia (Iron Deficient)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 1/17/62 to 1/18/62 , that I last saw the deceased alive on 1/17/62 , 19 62 , and that death occurred at 6:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 22 Md. DATE SIGNED 1/19/62 ACTUAL SIGNATURE W. E. McGreth PHYSICIAN'S NAME (Type) W. E. McGreth							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 22-62	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or county) (State) German Hill Rd. Balt. 22			
23. FUNERAL DIRECTOR'S SIGNATURE Frank Della Nave		ADDRESS 322 S. High		24a. REC'D BY REGISTRAR DATE JAN 22 '62	24b. REGISTRAR'S SIGNATURE W. S. Kraus		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



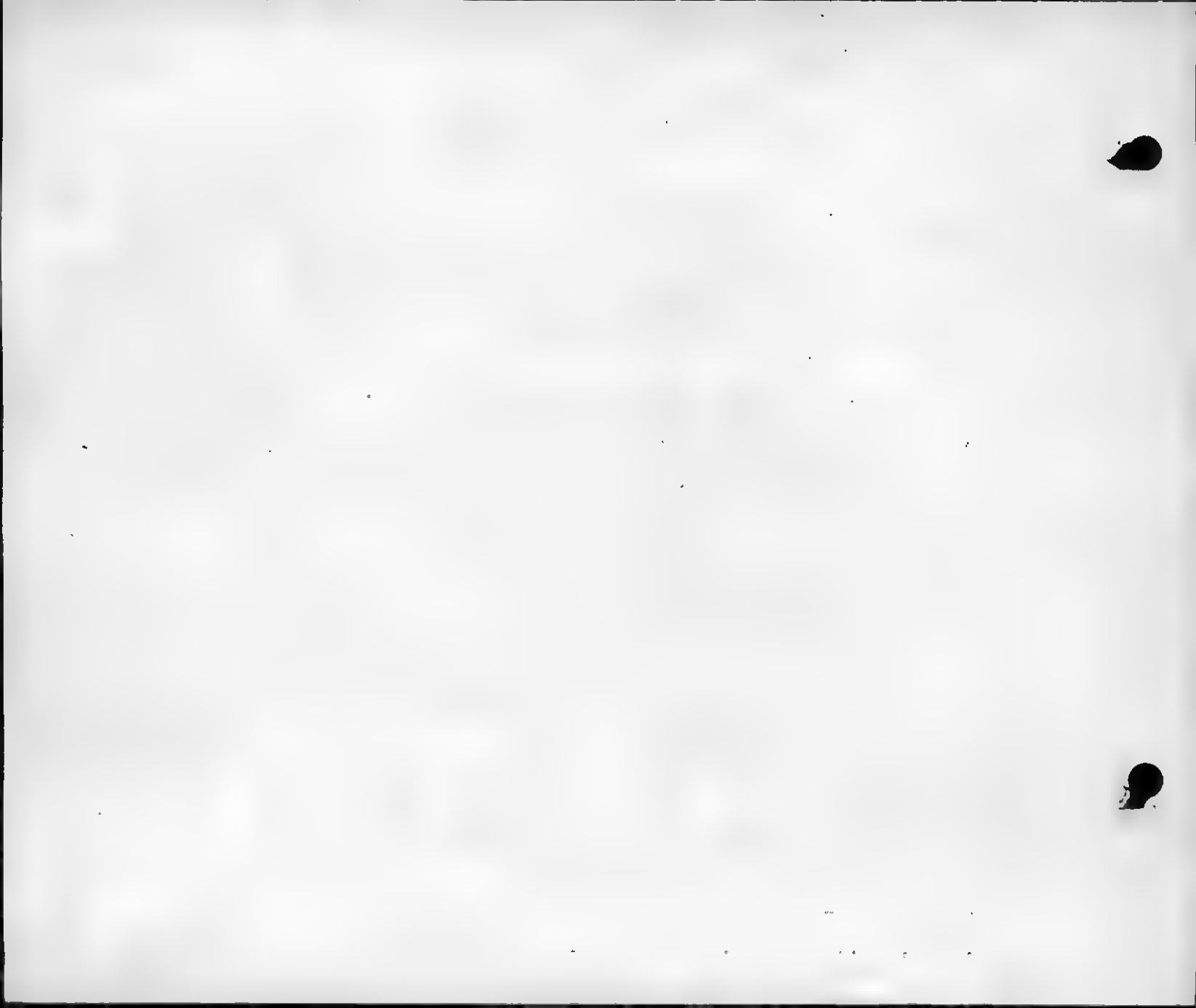
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00260

111257

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>So.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> <u>4</u>		c. LENGTH OF STAY IN 1b <u>2</u> <u>1/2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Children & Aged Men's Home</u>		d. STREET ADDRESS <u>1322 Linden Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Matth</u> Middle <u>-B.</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1867</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Loudon Co. Va.</u>	11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>
13. FATHER'S NAME <u>Armstrong M. Titus</u>		14. MOTHER'S MAIDEN NAME <u>Amelia A. Vertz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>Daisy E. Hamilton, 615 E. Pratt St</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> <u>Cardio-Renal arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>6 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>January 21, 1962</u> that (I) (we) last saw the deceased arrive on <u>January 20, 1962</u> and that death occurred at <u>10:40 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Newland Edward Day</u> M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>January 21, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Newland Edward Day</u>		22d. ADDRESS <u>4-E-33rd St Baltimore 18 Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1-24-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, Zone B</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>JAN 23 '62</u>		<u> </u>	



1
00261
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00258

1 PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 837 S. Kenwood Ave.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Josephs Nursing		e. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE Md.		b. COUNTY Balto.		City City	
3 NAME OF DECEASED (Type or print) Seweryna Zyzywoski		First Zyzywoski		Middle SALLY		Last GRYBOWSKI		4. DATE OF DEATH JAN 12 1962		Month JAN		Day 12	
5 SEX FEMALE		6 CO. OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH JAN 8 1877		9 AGE (in years last birthday) 83		IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) POLAND		12 CIT ZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT FRANK GRYBOWSKI		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver DUE TO (b) 3 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs		PART II OTHER SIGNIF CANT CONDIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from December 30 to Jan 12 1962 , that (I) (we) last saw the deceased alive on Jan 12 1962 and that death occurred at 10 P M, from the causes and on the date stated above.	
22a. SIGNATURE James E. Kone		22b. DATE 1/12/62		22c. PHYSICIAN'S NAME (Type) JAMES E. KONE		22d. ADDRESS 1011 FREDERICK RD #28		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. DATE 1/12/62		22g. SIGNATURE Walter S. Kone	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 1-16-62		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEM		23d. LOCATION (City, town, or county) (State) 6515 BOSTON ST		24 FUNERAL DIRECTOR'S SIGNATURE Marie Jialkowski		24a. REC'D BY REGISTRAR JAN 18 '62		24b. REGISTRAR'S SIGNATURE	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00254

1. PLACE OF DEATH
a. COUNTY BALTIMORE MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON
c. LENGTH OF STAY IN 1b 4 YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HART RD.
2. USUAL RESIDENCE (Where deceased lived, if institution. Residence entered before admission)
a. STATE MD. b. COUNTY BALTO.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON
d. STREET ADDRESS HART RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) MARY ANN GUY
4. DATE OF DEATH Month JAN Day 16 Year 1962
5. SEX F 6. COLOR OR RACE C 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 10-30-57 9. AGE (In years, last birthday) 4 yrs. F UNDER 1 YEAR Months Days F UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JAMES GUY 14. MOTHER'S MAIDEN NAME HELEN JACKSON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO 17. INFORMANT Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONITIS
DUE TO INFLUENZA
Conditions, if any, which gave rise to immediate cause (b) INFLUENZA
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour a.m. p.m. 19 While at work ☐ Not While at work ☐
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) TOWSON MD.
DATE SIGNED 1-16-62
ACTUAL SIGNATURE William A Pillsbury M.D.
EXAMINER'S NAME (Type) WILLIAM A PILLSBURY
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1-18-62 22c. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery 22d. LOCATION (City, town, or country) (State) Long Green Md.
23. FUNERAL DIRECTOR Wm G. Jackson Funeral Home ADDRESS 416 Penna Ave. 24a. REC'D BY REGISTRAR Arthur S. Kline 24b. REGISTRAR'S SIGNATURE Arthur S. Kline
DATE JAN 19 1962



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files of the Medical Examiner. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00260

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN MD d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3545 McShane Way		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk d. STREET ADDRESS 3545 Mc Shane Way e. SPECIAL INQUIRY ON A FARIAS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest Handslip		4. DATE OF DEATH Jan. 7, 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1891
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-ret.		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Handslip		14. MOTHER'S MAIDEN NAME Jane Purvis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO 213-07-9097	
17. INFORMANT Mrs. Florence Handslip		Address 3545 McShane Way-22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-Disease 422-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Spec. by)	22b. DATE THEREOF 1/10/62	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Colgate, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR JAN 10 '62	24b. REGISTRAR'S SIGNATURE 1/8/62

M

2



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00261

1 PLACE OF DEATH COUNTY BALTIMORE 4 MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE MARYLAND b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. CITY OR TOWN (If outside corporate limits write RJRAL and give nearest town) BALTIMORE 4 3-1-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AGED WOMEN + MEN HOME		d. STREET ADDRESS 501 ROSSITER AVE	
3 NAME OF DECEASED (Type or print) Mrs ANNA GORA First Middle Last HANSON		4 DATE OF DEATH JAN 13 1962 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11-1870 91 yrs
9 AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	11. BIRTHPLACE (State or foreign country) GREENLAND-CHARLES Co Md
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME JOHN D. HANSON	
14. MOTHER'S MAIDEN NAME MARY PRISCILLA CLEMENTS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		INFORMANT Address KATHLEEN YOUNG R.N.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 450 Conditions if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic changes to coronary artery DUE TO 2 years (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to Jan 13 , 19 62 , that I last saw the deceased alive on January 12 , 19 62 , and that death occurred at 12:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore DATE SIGNED 4-2 33rd St Dec 18 1962			
ACTUAL SIGNATURE Newland Edward Dey M.D.		PHYSICIAN'S NAME (Type) Newland Edward Dey, M.D. 4 East 33rd Street, Zone 18	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-16-62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23 FUNERAL DIRECTOR'S SIGNATURE Im. Cook-Inc., 1217 St. Paul Street, Zone 2		24a REC'D BY REGISTRAR JAN 16 '62	
24b REGISTRAR'S SIGNATURE William S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event with in 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please secure this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

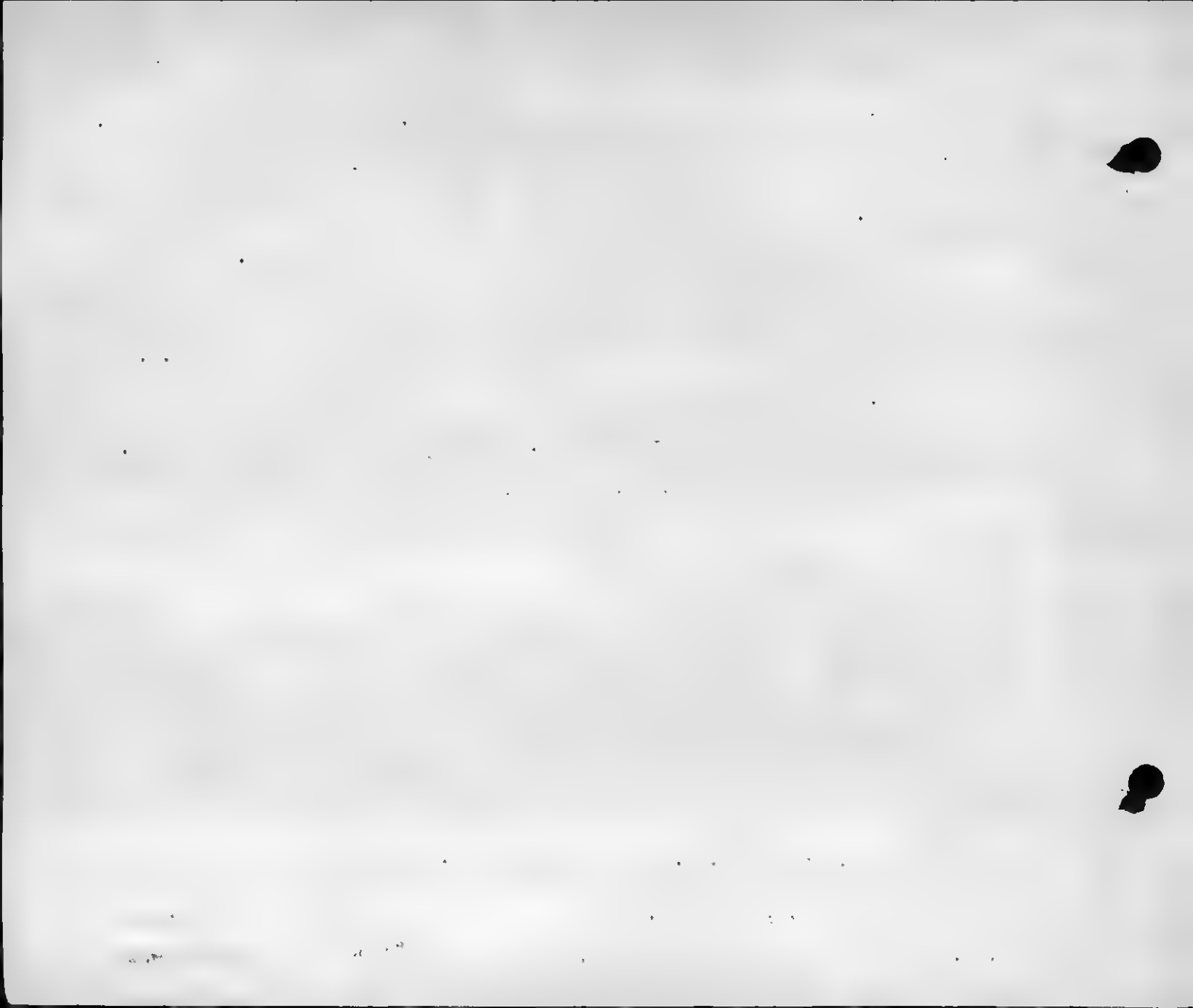
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00262

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> c. LENGTH OF STAY in town <u>35 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wilson Ave.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u> d. STREET ADDRESS <u>Wilson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John T. Harden</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>Jan. 2, 1962</u> Month Day Year 8. DATE OF BIRTH <u>May 6, 1886</u> 9. AGE (In years if UNDER 1 YEAR, if UNDER 24 HRS. last birthday) <u>75</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Harden</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>215-32-2319A</u> 17. INFORMANT <u>Mrs. Gadi W. Turner</u> Address <u>Baltimore 15, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C-V Disease</u> DUE TO (b) <u>none</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>none</u> DUE TO (c) <u>none</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 4, 62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Reisterstown, Md.</u>	
23. FUNERAL DIRECTOR <u>J. F. Eline</u> Sons Reisterstown, Md.		24a. REC'D BY REGISTRAR <u>JAN 5 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00266 00263											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1411 Langford Road						2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 1411 Langford Road					
3. NAME OF DECEASED (Type or print) BARBARA ANN HARRINGTON						4. DATE OF DEATH Month January Day 25 Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1957		9. AGE (In years last birthday) 4 yrs.		10. IF UNDER 1 YEAR: Months 4 Days 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Harrington		14. MOTHER'S MAIDEN NAME Betty Ann Rattenbury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. No.		17. INFORMANT Mr. John Harrington, 1411 Langford Rd.		Address		18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Bronchitis with early Bronchopneumonia DUE TO (b) 500X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a);		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month 1 Day 27 Year 19 62 Hour 5 a.m. 5 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty						M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Charles S. Petty, M.D.						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 1/27/62		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemty.		22d. LOCATION (City, town, or country) (State) Dorsey Md.	
23. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave.						ADDRESS		24a. REC'D BY REGISTRAR JAN 29 '62		24b. REGISTRAR'S SIGNATURE Charles S. Petty	



hours after death. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00267 CERTIFICATE OF DEATH 00264													
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN (b) 28 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1636 THAMES STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First MICHAEL Middle J Last HARTMANOWSKI				4. DATE OF DEATH Month January Day 12 Year 19 62									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/15/97		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER				10b. KIND OF BUSINESS OR INDUSTRY BARBER SHOP				11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME GEORGE E. HARTMANOWSKI				14. MOTHER'S MAIDEN NAME ANNA HOFFMAN									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES WWII				16. SOCIAL SECURITY NO. 218-22-5464				17. INFORMANT Clinical Records VAH Baltimore 18, Md.-Ft. Howard Division					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, TERMINAL ADENOCARCINOMA RIGHT KIDNEY CARCINOMATOSIS, GENERALIZED BENIGN PROSTATIC HYPERTROPHY ARTERIOSCLEROSIS GENERALIZED DUE TO (b) XXXXX Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) XXXXX PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECENT UNKNOWN UNKNOWN UNKNOWN UNKNOWN													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19													
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>													
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)													
20f. (City or town) (County) (State)													
21. I certify that (this hospital) attended the deceased from December 15, 19 61 to January 12, 19 62 , that (we) last saw the deceased alive on January 12, 19 62 , and that death occurred at 7:30 AM from the causes and on the date stated above.													
22a. SIGNATURE Thomas Crahan M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 1/12/62													
22c. PHYSICIAN'S NAME (Type) THOMAS CRAHAN 22d. ADDRESS VAH BALTO. 18, Md. Ft. Howard Div													
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan 15, 1962 23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland													
24. FUNERAL DIRECTOR'S SIGNATURE LILLY & ZEILER, Eastern Ave & Wolfe Sts, Balto. Md ADDRESS JAN 15 '62 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE C. S. Thomas													



Chen, S. S.

VR A1S (4)
15M 7 61



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00269

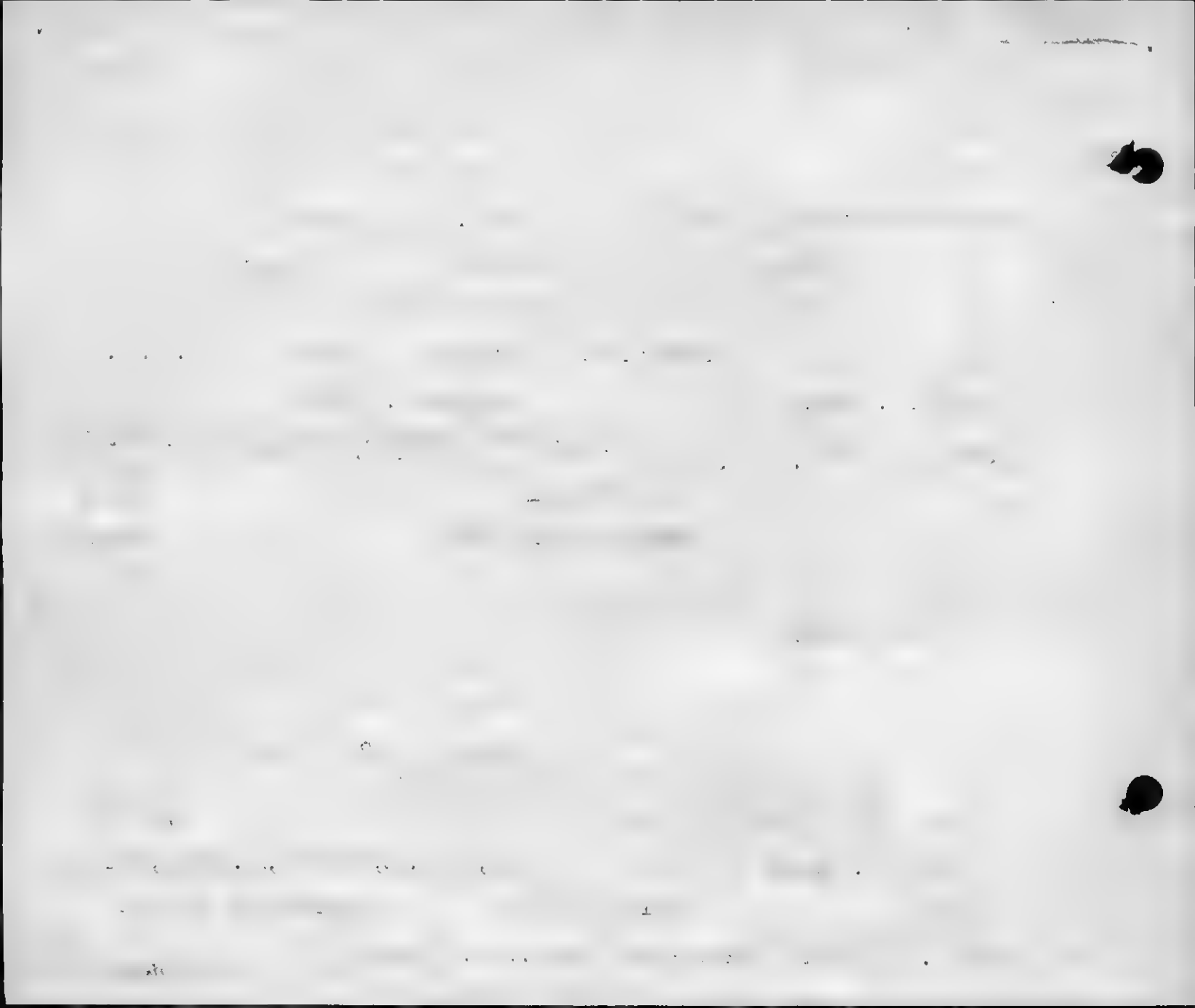
00266

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 29 c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Baltimore 29 d. STREET ADDRESS 126 S. Loudon Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM E HOLMES		4. DATE OF DEATH Month January Day 11 Year 1962		9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday Months Days Hours Min. 39 yrs.	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer		11b. KIND OF BUSINESS OR INDUSTRY Lumber Yard		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME WILLIAM E. HOLMES		14. MOTHER'S MAIDEN NAME WINIFRED M. SWIFT		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES WWII		16. SOCIAL SECURITY NO 218-12-4894		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO BRONCHOPNEUMONIA PORTAL CIRRHOSIS LIVER				INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ATROPHY TESTES					
20a. TIME OF INJURY Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, BALTO. 18, MARYLAND, FT. HOWARD, MARYLAND	
21. I certify that (this hospital) attended the deceased from January 9, 1962 , to January 11, 1962 , that (we) last saw the deceased alive on January 11, 1962 , and that death occurred at 3:15 PM , from the causes and on the date stated above.		22a. SIGNATURE <i>Thomas F. Crahan</i> M.D. 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN		22b. DATE SIGNED 1/12/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-15-62		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	
24. JUNE 1, DIRECTOR'S SIGNATURE <i>George L. Schwab</i>		25a. REC'D BY REGISTRAR DATE JAN 15 '62		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kneen</i>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

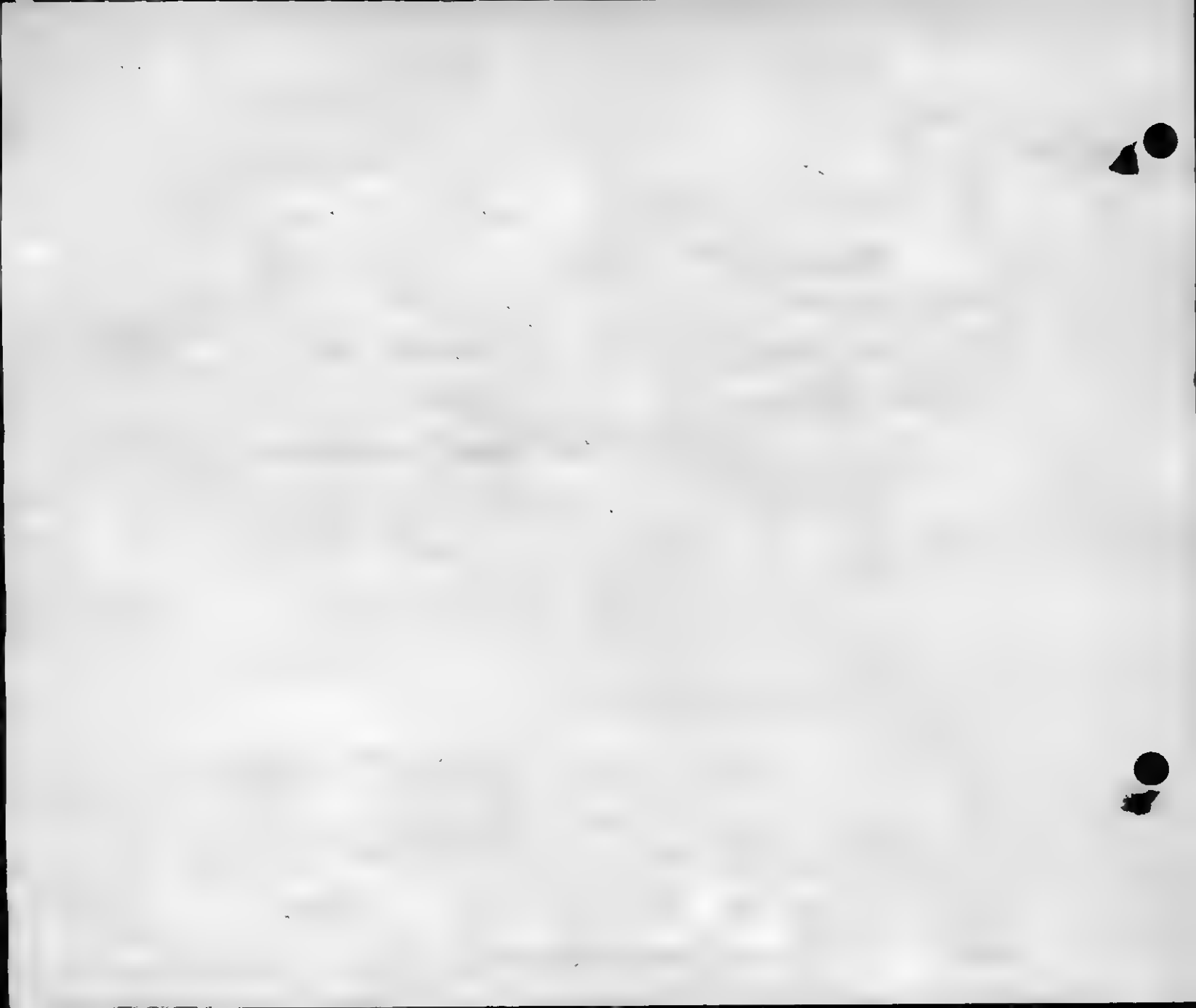
00270

00267

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> c. LENGTH OF STAY IN 1b <u>(24)</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 14 Box 482</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River</u> d. STREET ADDRESS <u>Rt. 14 Box 482</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles L. Horn</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1962</u>							
5. SEX <u>Male</u>		6. CO. OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 6 - 1873</u>					
9. AGE (In years last birthday) <u>89</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.						
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months Days	Hours Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber Business (Retired)</u> 10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Adam Horn</u>				14. MOTHER'S MAIDEN NAME <u>Katherine ?</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO <u>219-10-0874</u>							
17. INFORMANT <u>Evelyn Norris (same as above)</u>				Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial infarct</u> (c) <u>Generalized arteriosclerosis</u> (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 1/2 years</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Chronic pyelonephritis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT W/ UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)		(County)		(State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 24, 1961</u> to <u>Jan 23, 1962</u> that (I) (we) last saw the deceased alive on <u>Dec 30 1961</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>A. Lewis Kolodny</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/26/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>A. LEWIS KOLODNY MD</u>				22d. ADDRESS <u>1825 Eastern Blvd. Balto. Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-26-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rt. Carmel</u>		23d. LOCATION (City, town or county) <u>Balto. Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>				25a. REC'D BY REGISTRAR <u>48 Eastern Blvd.</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Harris</u>							
DATE <u>JAN 29 '62</u>											

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician must be present at the death. The law requires that the death certificate be executed within 24 hours after death. The attending physician must be present at the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health permit, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

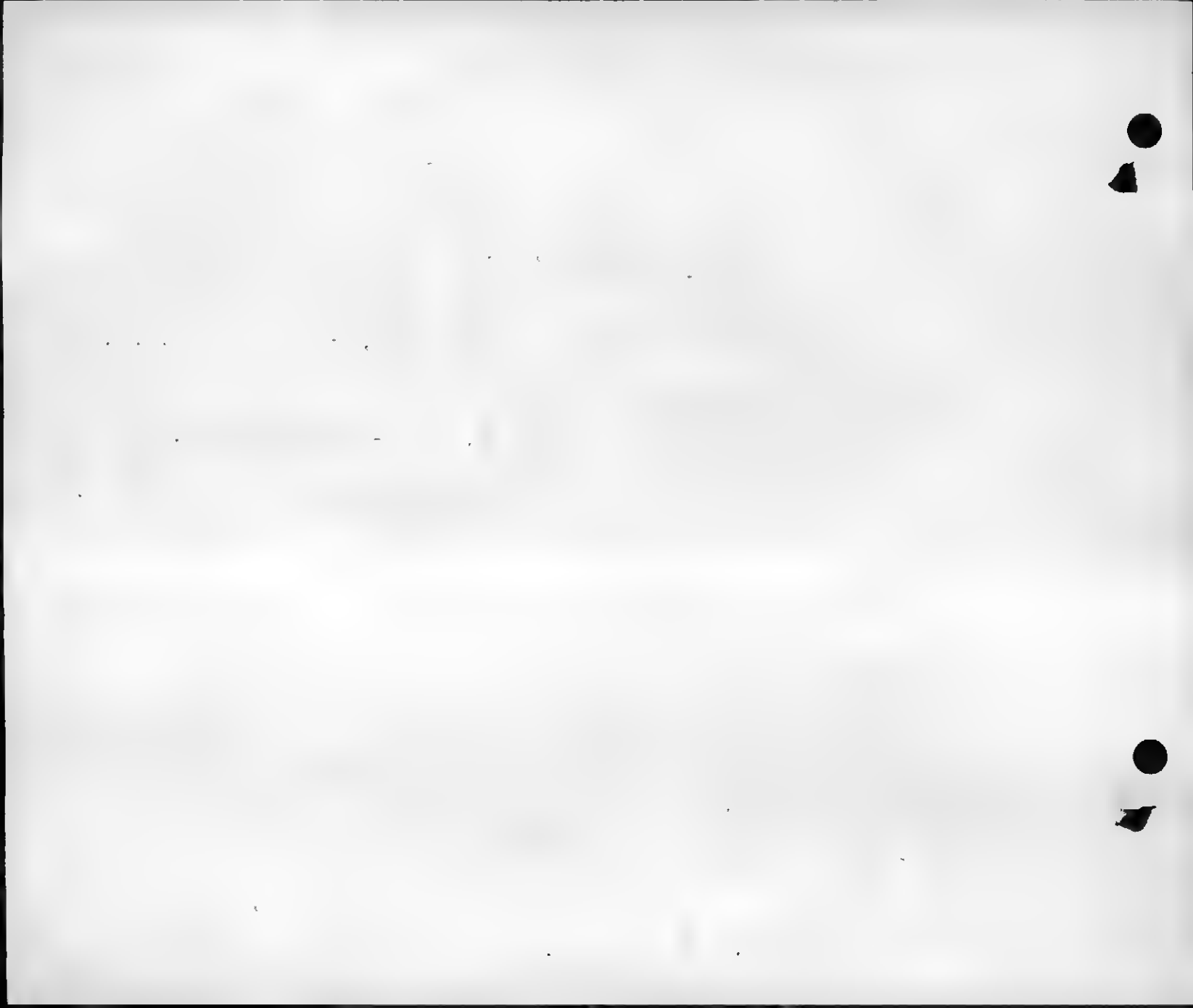
CERTIFICATE OF DEATH

00271

Item 9 Film 8305 1/25/62 ink

00268

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN lb X Randallstown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7919 Liberty Road		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Randallstown d. STREET ADDRESS 7919 Liberty Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julius Middle Houff, Sr. Last Houff, Sr.		4. DATE OF DEATH Month January Day 18, Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1887 9. AGE (In years last birthday) 74 7/8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Dealer		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Gustav Houff	
14. MOTHER'S MAIDEN NAME Artha Elizabeth Stump		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) None	
16. SOCIAL SECURITY NO. None		17. INFORMANT Helen M. Houff - 7919 Liberty Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 16, 1962 to Jan 18, 1962 , that (I) (we) last saw the deceased alive on Jan 16, 1962 and that death occurred at 11 AM , from the causes and on the date stated above.			
22a. SIGNATURE Edwin L. Pierpont		22b. DATE SIGNED Jan 18, 1962	
22c. PHYSICIAN'S NAME (Type) 8204 LIBERTY RD		22d. ADDRESS 8204 LIBERTY RD. - BALTO. 7.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/22/62	23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		25a. REC'D BY REGISTRAR DATE JAN 24 '62	
25b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00272

item 7 Film G-00 1/3/62 iwk

Reg. Dist. No.

00269

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

BALTO

MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)

a. STATE Md.

b. COUNTY Balto

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Buena Balto

c. LENGTH OF STAY IN 1b

2 yr.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Balto - rural - Rosedale

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

1 8300 Pulaski Highway

• IS RESIDENT ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

(Hopeace) Robert Hudson

4. DATE OF DEATH

Month Day Year
Jan 3 1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11 Aug 1899

9. AGE (Years and birthday)

62 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Handyman

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Logan, Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Porter Hudson

14. MOTHER'S MAIDEN NAME

Rosa Stella Thatcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO

215-22-0123

17. INFORMANT

Own Records

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary Edema

DUETO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUETO

Cardiac Failure

DUETO

Rheumatic Cardiac vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

hrs.

chronic?

undist?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour o. m. p. m.

19

20d. INJURY OCCURRED

While of work ☐ Not while of work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

John C. Hyle

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Jan 3 - 62

22a. BURIAL CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1-8-62

22c. NAME OF CEMETERY OR CREMATORY

Hazlehurst, Ga.

22d. LOCATION (City, town, or county)

Hazlehurst, Ga.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Ellsworth Armacost

ADDRESS

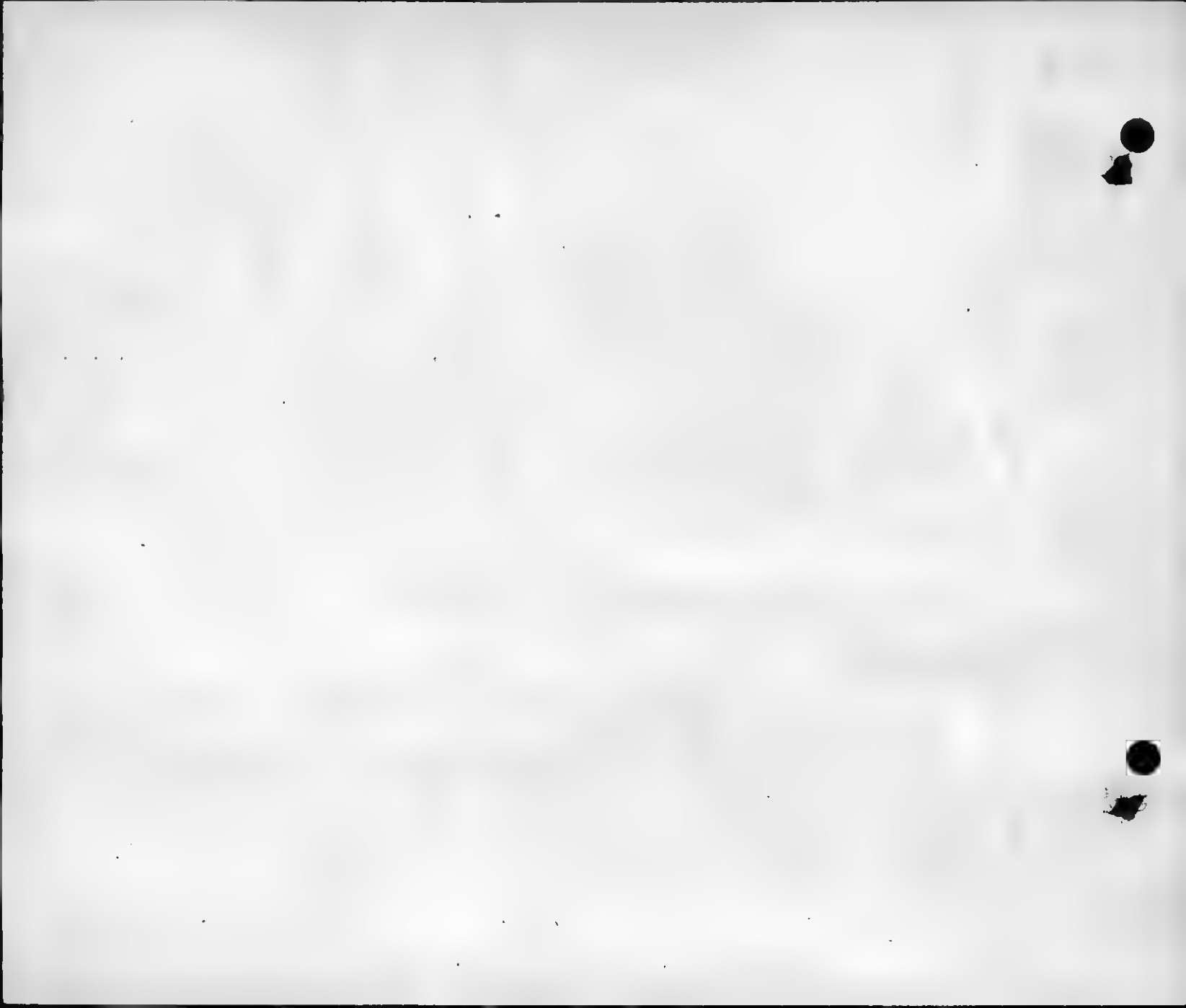
24a. REC'D BY REGISTRAR

DATE JAN 4 '62

24b. REGISTRAR'S SIGNATURE

William L. Thayer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director to execute the certificate. The certificate should be filed in the office of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the funeral director. FOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

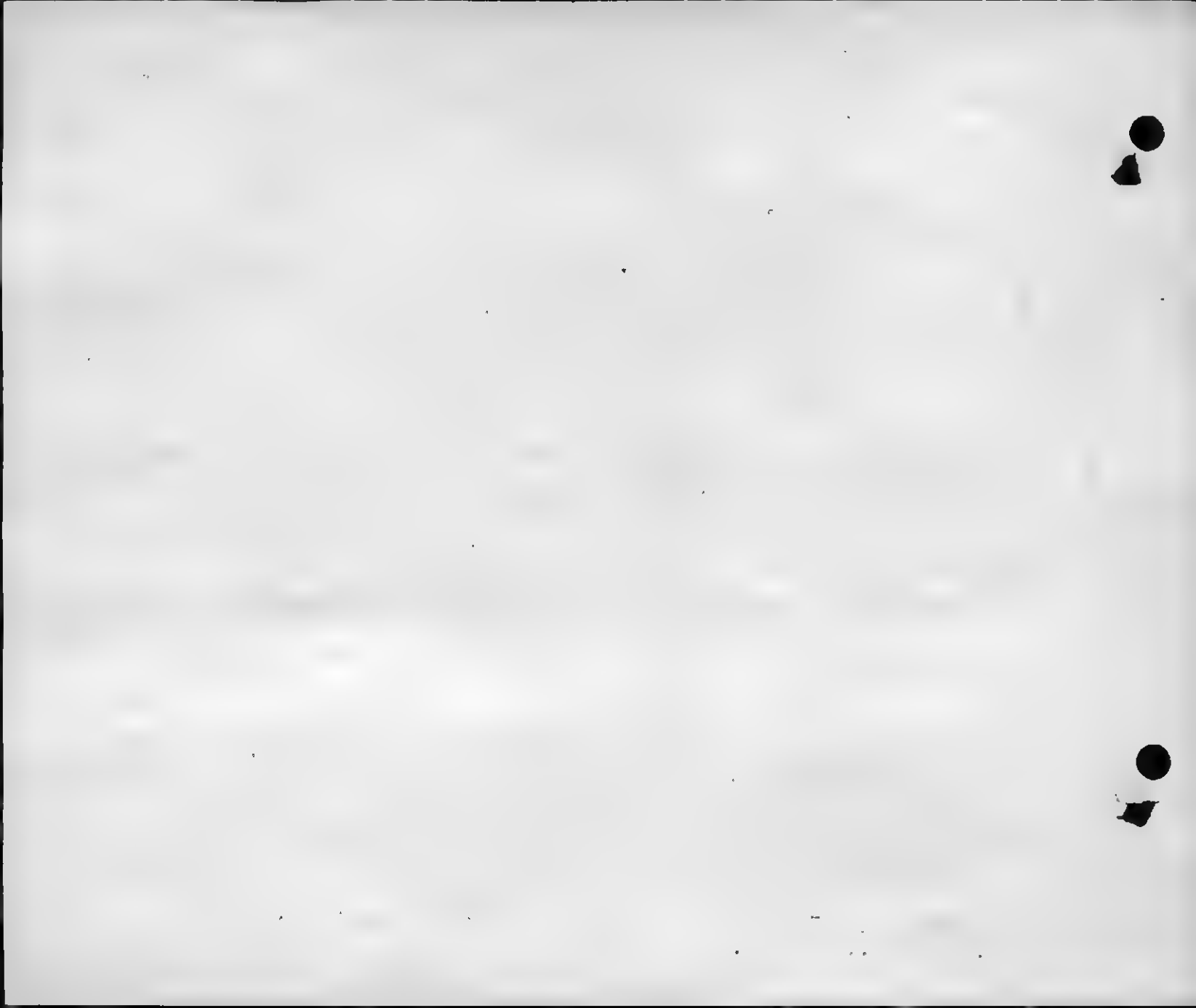
VR A15 (4)
15M 9/60

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00273
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17
1
MAY 1962
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
00270

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institutions Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>45 yr 10 mo 3 dys</u>				d. STREET ADDRESS <u>3017 West North Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hiram</u> <u>W.</u> <u>Hughlett</u>				4. DATE OF DEATH Month Day Year <u>January</u> <u>5</u> <u>19 62</u>			
5. SEX <u>male</u>				6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>Oct., 1884</u>			
9. AGE (In years last birthday) <u>77</u> yrs.				10. IF UNDER 1 YEAR Months Days Hours Min. <u>77</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Hartwell Hughlett</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>				Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Congestive heart failure</u> (c) <u>Arteriosclerotic heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>weeks</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (If (this hospital) attended the deceased from... <u>March 2, 1936</u> to <u>Jan. 5, 1962</u> , that (I) (we) last saw the deceased alive on... <u>Jan. 5, 1962</u> , and that death occurred at <u>12:45</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Jose R. Ortizaga, H.D.</u>				22b. DATE SIGNED <u>1-5-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARTZAGA, H.D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 26, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1-9-62</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>				23d. LOCATION (City, town or county) <u>Elkridge, Maryland</u> (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 8 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is expected, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9,60

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MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)			
a. COUNTY Baltimore				a. STATE Maryland			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22)				b. COUNTY Baltimore			
c. LENGTH OF STAY IN 1b 6 years				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 235 River View Avenue				d. STREET ADDRESS 235 River View Avenue			
3. NAME OF DECEASED (Type or print) ETTA MAE INGALLS				4. DATE OF DEATH January 23rd, 1962			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1883	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Christopher Watkins				14. MOTHER'S MAIDEN NAME Emma (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Charles H.N. Ingalls Address same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive + Atherosclerosis DUE TO (b) DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Melvin B. Davis, M.D.				DATE SIGNED 1/25/62			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/62		22c. NAME OF CEMETERY OR CREMATORY Cedar Grove Cemetery		22d. LOCATION (City, town, or country) (State) Cedar Grove, Maryland	
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR JAN 26 '62			
				24b. REGISTRAR'S SIGNATURE [Signature]			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **40271**

00274

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 22 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res. Box 66, Chestnut Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Eva		4. DATE OF DEATH Month Jan. Day 20 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1882
9. AGE (In years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 15 Min 15	11. IF UNDER 24 HRS Months 7 Days 15 Hours 15 Min 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Tavern Keeper		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Gephardt.		14. MOTHER'S MAIDEN NAME Eva ???	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-0496	
17. INFORMANT Charles James Jr.		Address 2525 Mc Comas Ave. 22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Arterio-sclerosis - generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerosis - generalized (c) Arterio-sclerosis - generalized		INTERVAL BETWEEN ONSET AND DEATH 30 hrs. ? 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis - generalized		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19, 1962 to Jan 20, 1962 , that I last saw the deceased alive on Jan 19, 1962 , and that death occurred at 7 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 520 D St. Balt. Md. DATE SIGNED 1.23.62	
ACTUAL SIGNATURE ROGER G. WINDSOR		PHYSICIAN'S NAME (Type) ROGER G. WINDSOR	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-1962	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR DATE JAN 24 '62		24b. REGISTRAR'S SIGNATURE Clifford A. Knead	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11273

00276

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henry</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>900 Hyde Park Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Back River</u> d. STREET ADDRESS <u>900 Hyde Park Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALDO</u> First <u>Lee</u> Middle <u>Johnson</u> Last DATE OF DEATH Month <u>1-</u> Day <u>13-</u> Year <u>1962</u>				9. AGE (In years last birthday) yrs. <u>3</u> Months <u>13</u> Days _____ Hours _____ Min. _____ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____ 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? _____			
5. SEX <u>M.</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 17, 1961</u>				13. FATHER'S NAME <u>Collins Johnson</u> 14. MOTHER'S MAIDEN NAME <u>Beatrice Cherry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ If yes, give war or dates of service _____ 16. SOCIAL SECURITY NO. _____ 17. INFORMANT _____ Address _____				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>491X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____ 20c. TIME OF INJURY Month, Day, Year _____ Hour a. m. _____ p. m. _____ 19____ 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jack E Collins</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Jack E Collins</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>1-17-62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Anthony</u> 22d. LOCATION (City, town, or county) <u>St. Anne</u> (State) <u>C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas C. Wilson</u> ADDRESS <u>St. Anthony</u> 24a. REC'D BY REGISTRAR _____ 24b. REGISTRAR'S SIGNATURE _____ DATE _____				1-13-62			

20331833V+

TO DEPUTY MEDICAL EXAMINER: This Certificate should be executed within 48 hours after death. If any delay is necessary, the certificate should be signed by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit.



TO HOSPITAL OR TO FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

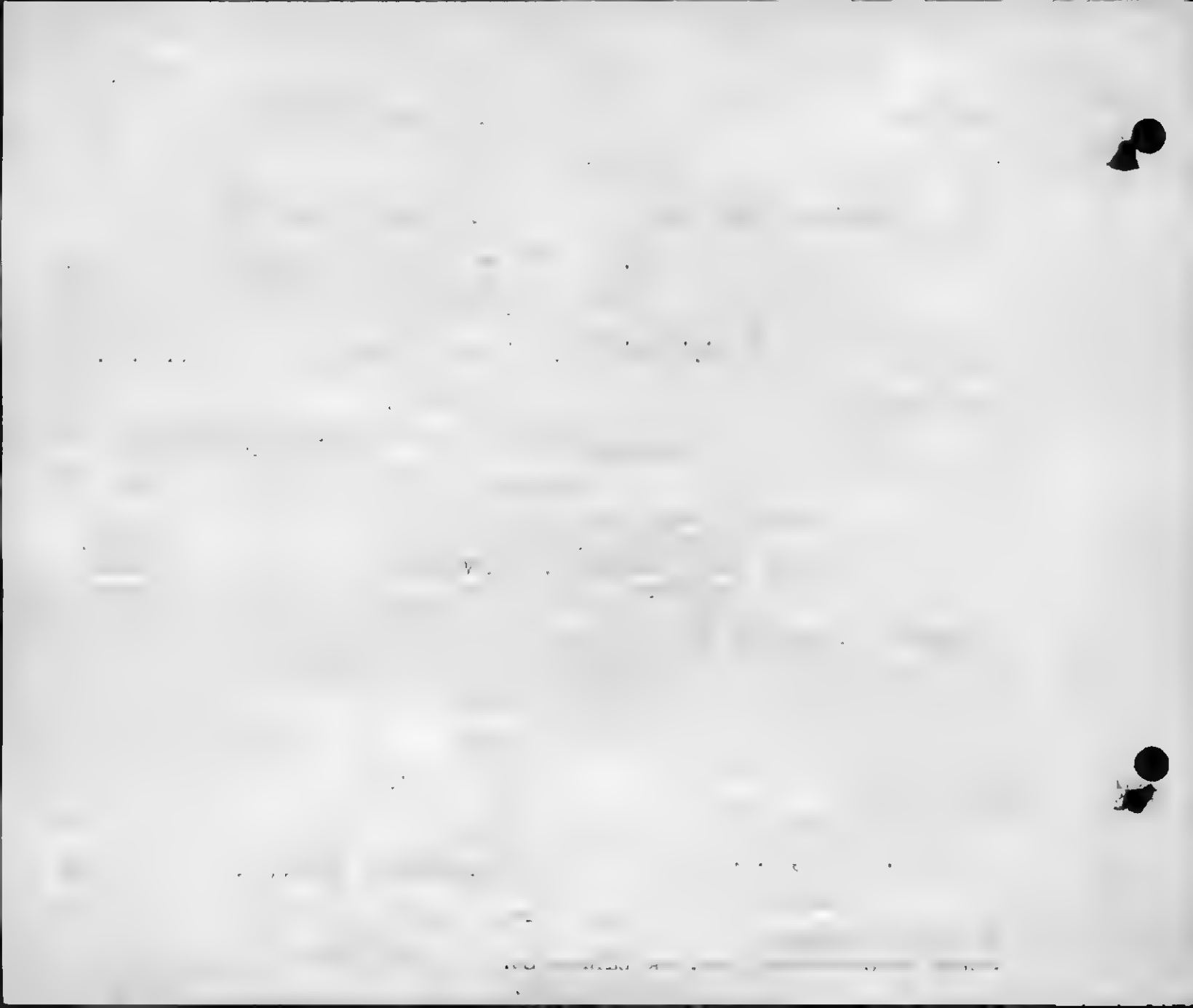
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00277

00274

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 15 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 16 d. STREET ADDRESS 2324 North Longwood Street	
3. NAME OF DECEASED (Type or print) ALPHONSUS S. JOHNSON e. SEX Male f. COLOR OR RACE Negro g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> h. DATE OF BIRTH October 9, 1913 i. AGE (in years last birthday) 48 yrs.		4. DATE OF DEATH January 19, 1962 j. IS RESIDENCE IN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor U.S. Govt. Civil Serv. Gen. Service Adm. k. BIRTHPLACE (County & State) or foreign country Bowie, Maryland l. CITIZEN OF WHAT COUNTRY? U. S. A.		11. BIRTHPLACE (County & State) or foreign country Bowie, Maryland m. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Johnson n. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II o. SOCIAL SECURITY NO. 217-07-6444		14. MOTHER'S MAIDEN NAME Mary Prout p. ADDRESS Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 XXXX PULMONARY INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXX RHEUMATIC HEART DISEASE XXXX MURAL THROMBOSIS, LEFT VENTRICLE CONGESTIVE HEART FAILURE		INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT UNKNOWN RECENT RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INFARCTS, KIDNEYS AND SPLEEN - RECENT		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) January 4, 1962 January 19, 1962		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 4, 1962 , to January 19, 1962 , that (X) (we) last saw the deceased alive on January 19, 1962 , and that death occurred at 8:10 A.M. from the causes and on the date stated above.	
22a. SIGNATURE Thomas F. Crahan 22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D.		22b. DATE SIGNED 1/19/62 22d. ADDRESS VAH, BALTIMORE 18 MD., FT. HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-23-62 23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery 23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE George Kelson 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25c. DATE JAN 22 '62 George Kelson Funeral Home, 1348 Calhoun St. Baltimore, Md.	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

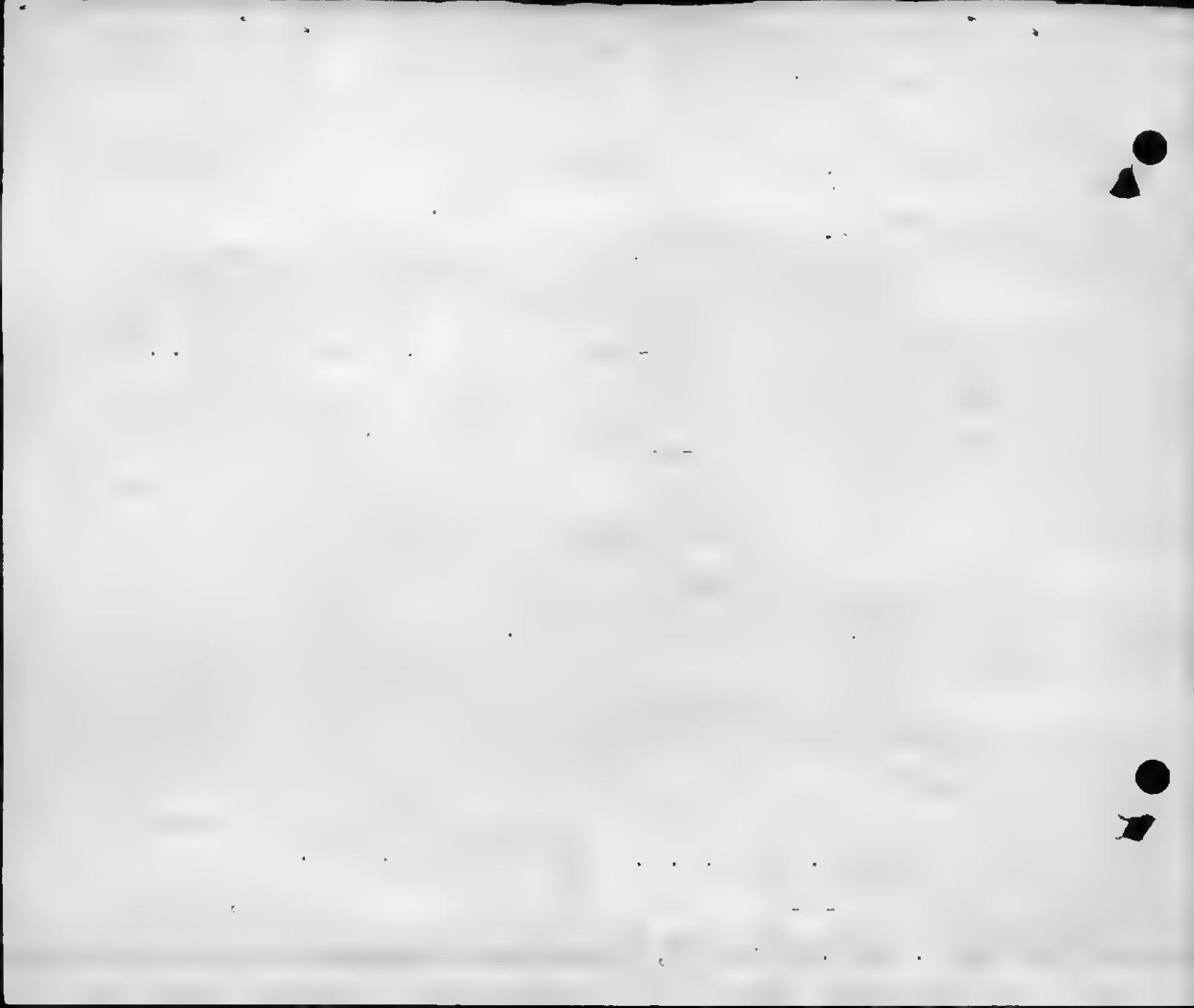
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

100275

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31	
c. LENGTH OF STAY IN 1b 125 Days		d. STREET ADDRESS 117 N. Wolfe Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles -- Johnson		4. DATE OF DEATH Month January Day 20 Year 1962	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH September 13 1896		9. AGE (In years if UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. 65 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Produce-Market	
11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Columbus Johnson		14. MOTHER'S MAIDEN NAME Nettie Hillyard	
15. DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1218-03-8829	
17. INFORMANT Clinical Records, VAH, Fort Howard Division		18. ADDRESS Baltimore 18, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA 610X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PYELONEPHRITIS (c) PROSTATIC HYPERTROPHY		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RT HEMIPARESIS DUE TO CEREBRAL THROMBOSIS. BRONCHOPNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 161		20f. (City or town) (County) (State) 161, to Jan. 20, 1962	
21. I certify that 30 (this hospital) attended the deceased from Sep 17 , 1961 , to Jan. 20 , 1962 , that 4 (we) last saw the deceased alive on Jan 20 , 1962 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE J. D. Talbert		22b. DATE SIGNED 1/20/62	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH, Balto. 18 Md., Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON, Baltimore 17, Maryland		25a. REC'D BY REGISTRAR JAN 31 '62	
25b. REGISTRAR'S SIGNATURE W. H. H. H. H.		25c. REGISTRAR'S SIGNATURE W. H. H. H. H.	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, these eye-
 culate the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.
 TO CHIEF MEDICAL EXAMINER'S Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.

VS. A15ME(5)
 SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

00279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **W1276**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastpoint		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eastpoint			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8033 Bank Street				d. STREET ADDRESS 8033 Bank Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Elmer Last Keenan				4. DATE OF DEATH Month January Day 15 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1891		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Private Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Keenan				14. MOTHER'S MAIDEN NAME Marianna Clements			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Rae Mulligan-8033 Bank Avenue-Eastpoint			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX DUE TO (b) 61X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. 61X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3-4 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-62		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 1 m. J. [Signature]				ADDRESS 1212 [Address]		24a. REC'D BY REGISTRAR 8 62	
				DATE 1/16/62		24b. REGISTRAR'S SIGNATURE [Signature]	

DATE SIGNED
1/16/62



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

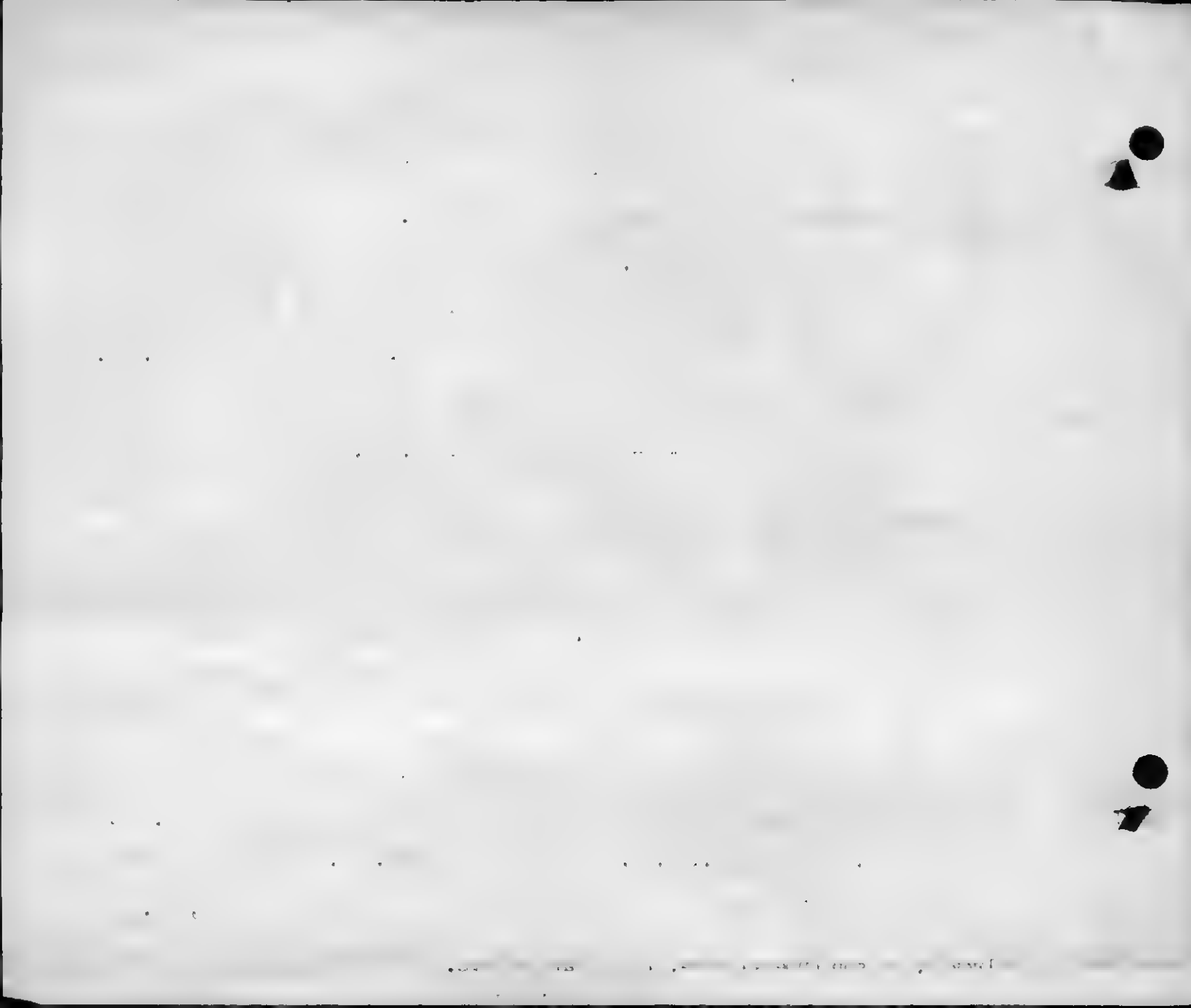
CERTIFICATE OF DEATH

00280

00277

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT HOWARD</u> c. LENGTH OF STAY IN lb <u>189 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1907 N. Castle Street</u>		3. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>REGINALD I. KELLY</u>		4. DATE OF DEATH Last <u>January</u> 21, 1962		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13, 1923</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Night Clubs</u>		9. AGE (In years last birthday) <u>38</u> yrs. 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Bernard Harris</u>		14. MOTHER'S MAIDEN NAME <u>Emma Kelly</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>216-14-0409</u>		17. INFORMANT <u>Clinical Records, VA Hospital</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE. LEFT CEREBRAL VASCULAR ACCIDENT</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>16 July 16, 1961</u> , to <u>January 21, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 21, 1962</u> , and that death occurred at <u>9:15AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Jan. 21, 1962</u>		22c. PHYSICIAN'S NAME (Type) <u>F. LEACOCK, JR., M. D.</u>	
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>1-25-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
23d. LOCATION (City, town or county) <u>Baltimore 28, Md.</u>		23e. (State)		23f. (County)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u>		24a. ADDRESS <u>1000 Brantley Ave. Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 31 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		25c. REGISTRAR'S NAME <u>[Signature]</u>		25d. REGISTRAR'S ADDRESS	

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00281

111278

1. PLACE OF DEATH
a. COUNTY BALTIMORE
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) OWINGS MILLS
c. LENGTH OF STAY N 1b 4 mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROSEWOOD STATE TRAINING SCHOOL

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE MARYLAND b. COUNTY PRINCE GEORGE
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) CHEVERLY
d. STREET ADDRESS 6203 FOREST ROAD

3. NAME OF DECEASED (Type or print) AGNES MARIE KERLEY

4. DATE OF DEATH 1 13 19 62

5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 12-3-60

9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR, Months Days Hours Min. 13 19 62

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WASHINGTON D.C. U.S.A.
10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON D.C. U.S.A.
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JAMES JOSEPH KERLEY, JR.
14. MOTHER'S MAIDEN NAME MARY AGNES BIER KERLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? ☐ 16. SOCIAL SECURITY NO. 17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute tracheo-bronchitis and bronchopneumonia
DUE TO (b) Tracheostomy
DUE TO (c) Tracheostomy

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-13-60, 1961 to 1-13, 1962 that (I) (we) last saw the deceased alive on 1-13, 1962 and that death occurred at 11:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE Ernest I. DeC... M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED 1/13/62

22c. PHYSICIAN'S NAME (Type) ERNEST I. DE... 22d. ADDRESS ...

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan 15, 1962 23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery 23d. LOCATION (City, town or county) (State) Washington D.C.

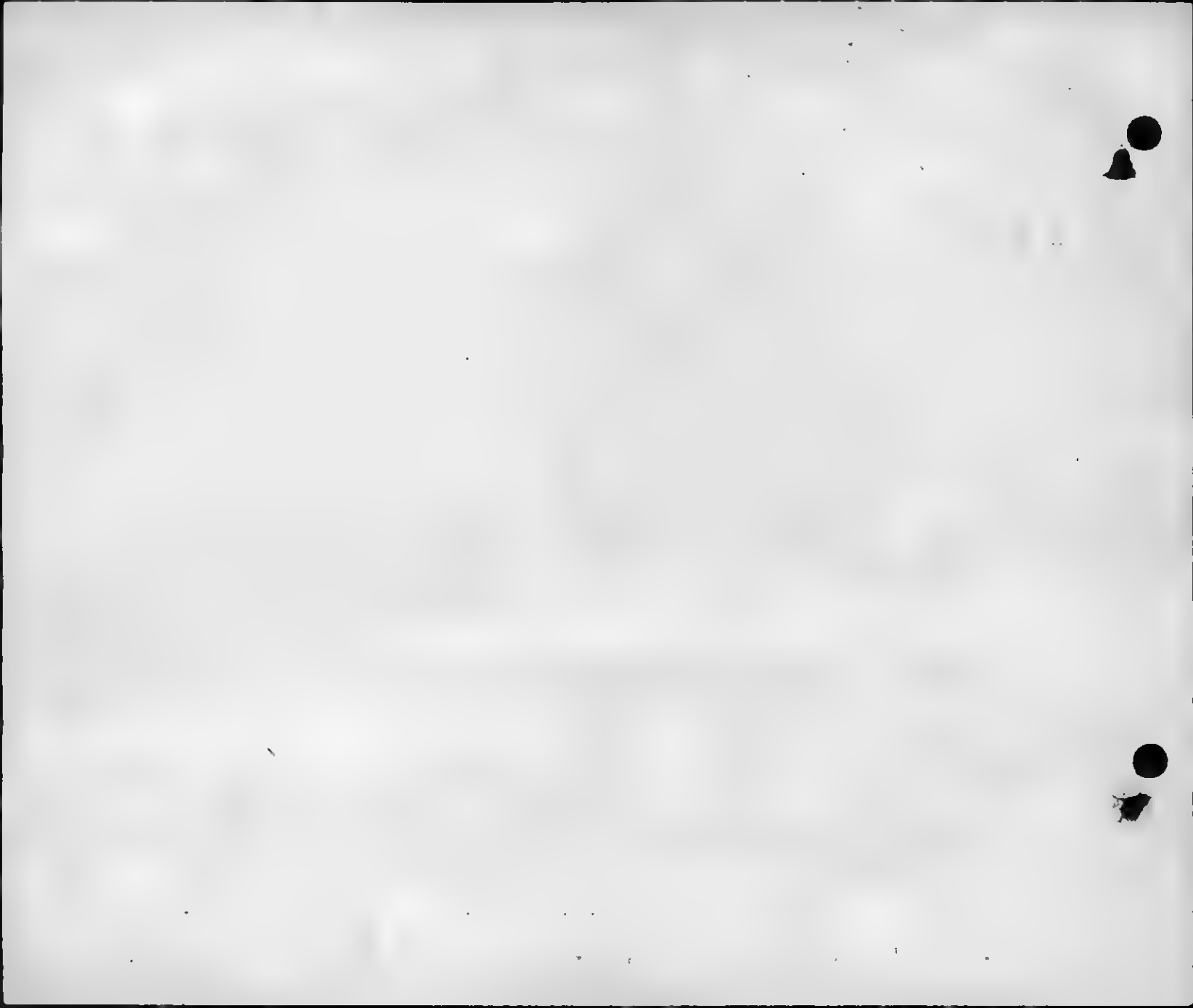
24. FUNERAL DIRECTOR'S SIGNATURE Gasch's Sons ADDRESS Hyattsville, Md. 25a. REC'D BY REGISTRAR JAN 17 '62 25b. REGISTRAR'S SIGNATURE ...

MEDICAL CERTIFICATION

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR AFTER DEATH: The form requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00282											
06279											
1. PLACE OF DEATH a. COUNTY BALTO.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1500 SUMMIT AVE.				d. STREET ADDRESS 1500 SUMMIT AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) TERESA L. KERR				4. DATE OF DEATH JAN. 1 1962				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX F				6. COLOR OR RACE W				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH AUG. 12, 1882				9. AGE (In years last birthday) 79 yrs.				10. IF UNDER 1 YEAR: Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER				10b. KIND OF BUSINESS OR INDUSTRY HOME				11. BIRTHPLACE (County & State, or foreign country) MD			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME PATRICK CORBITT				14. MOTHER'S MAIDEN NAME MARGARET RYAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT MARGARET RYAN			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 4. X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Acute Gastric dilatation Renal-cardio-vascular disease hypotension, senility				INTERVAL BETWEEN ONSET AND DEATH				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/30 , 19 61 , to 1-1-62 , 19 62 , that (I) (we) last saw the deceased alive on 12/30 , 19 61 , and that death occurred at 1:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Andres E. Cairns				22b. DATE SIGNED 1-1-62				22c. PHYSICIAN'S NAME (Type) Andres E. Cairns			
22d. ADDRESS 4 M. Sullivan Ave.				22e. REC'D BY REGISTRAR JAN 4 '62				22f. REGISTRAR'S SIGNATURE Charles L. Hume			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-4-62				23c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.			
23d. LOCATION (City, town or county) Balto.				23e. (State) MD.				23f. FUNERAL DIRECTOR'S SIGNATURE Frederick Covington L. F.H. Catonsville, Md.			



1
Page 1
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The physician, the hospital or funeral director, or the registrar may be retained to complete the certificate. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - MARYLAND, 18

Item 14, Funeral Home's Form 1-1/2, 6/2/51

00283

CERTIFICATE OF DEATH

Reg. Dist. No. 00280

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		e. STREET ADDRESS 4851 Truesdale Avenue	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EARL Last KIMMELSHUE		4. DATE OF DEATH Month January Day 14 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1888
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George E. Kimmelshue		14. MOTHER'S MAIDEN NAME Mary Lettler Moser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-9055	
17. INFORMANT Mrs. Thersa Kimmelshue-4851 Truesdale Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Ch. Arteriosclerotic Cardio-Vascular Disease DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 23, 1961 , to January 14, 1962 , that I last saw the deceased alive on January 14, 1962 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher M.D.		DATE SIGNED 1/15/62	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D. 6209 Frederick Ave. Balt. 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 17, 1962	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC., Balto., Md.		ADDRESS	
24a. REC'D BY REGISTRAR JAN 17 '62		DATE	
24b. REGISTRAR'S SIGNATURE Arthur J. Hume		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00284

00281

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore -22</u> d. STREET ADDRESS <u>2606 Ambler Road</u>	
3. NAME OF DECEASED (Type or print) First <u>GILBERT</u> Middle <u>P.</u> Last <u>KLATT</u>		4. DATE OF DEATH Month <u>January</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3/13/22</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronics Repairman</u>		11. BIRTHPLACE (County & State or foreign country) <u>Baltimore, Maryland</u>	
13. FATHER'S NAME <u>Gilbert P. Klatt</u>		14. MOTHER'S MAIDEN NAME <u>Leona Seal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>214-14-8131</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO-INTESTINAL BLEEDING</u> 572.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>ULCERATIVE COLITIS</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		17. INFORMANT <u>Clinical Records VA Hospital</u> <u>Baltimore 18, Maryland -FORT HOWARD DIVISION</u> INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u> <u>15 years</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Dec. 31, 1961</u> to <u>Jan. 21, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Jan. 21, 1962</u> , and that death occurred at <u>10:10 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Ferdinand Leack, Jr., M.D.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ferdinand Leack, Jr., M.D.</u>		22d. ADDRESS <u>VAH Balto, Md-Fort Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-21-62</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>		25c. DATE <u>1/21/62</u>	

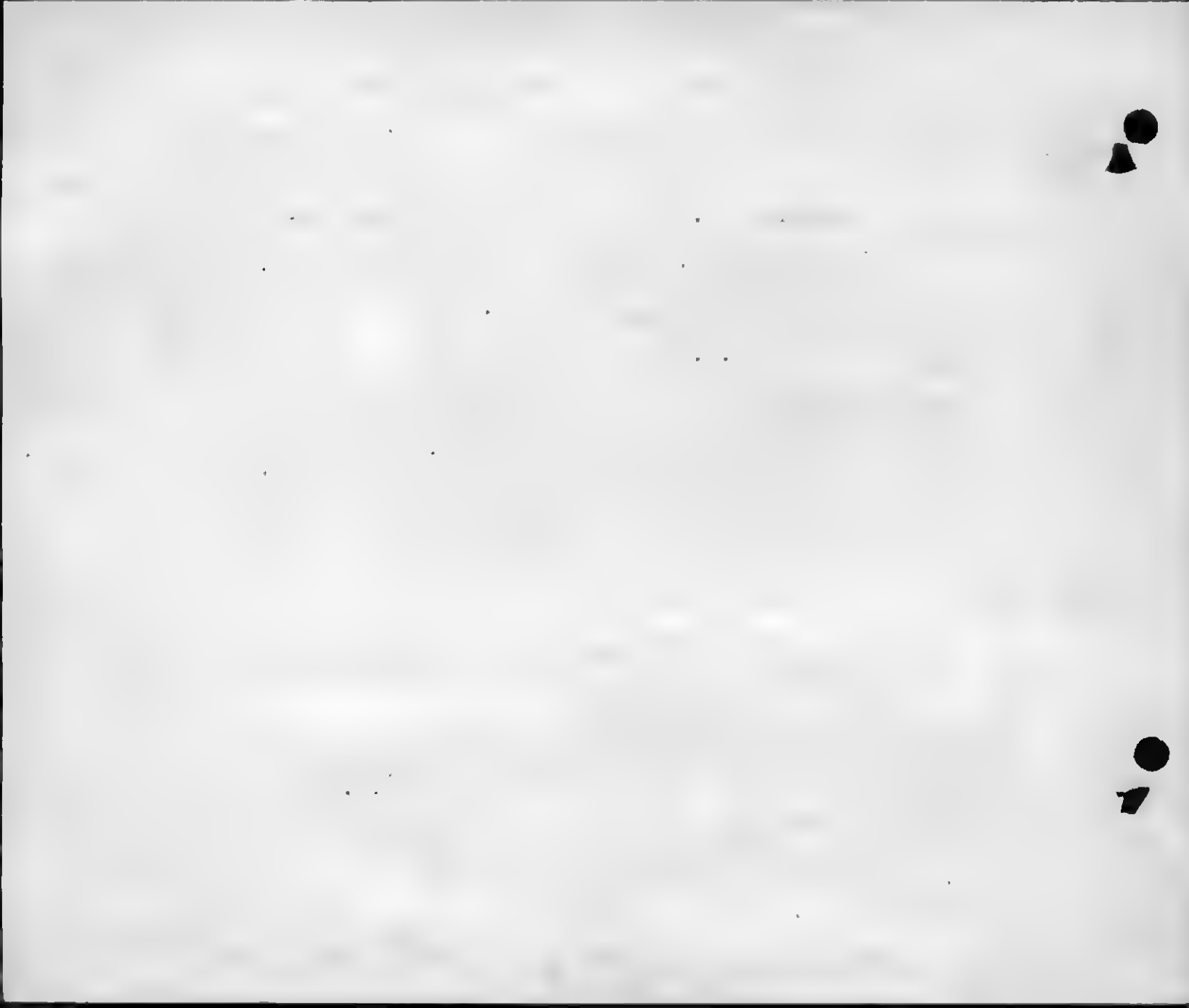
VR A15 (4)
15M 9/60



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 14 days after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div>1</div> <div>00285</div> <div>Item 14 Film 0305</div> <div>1/16/62</div> <div>100282</div>									
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div>					<div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>a. STATE</div>				
<div>Baltimore</div> <div>MARYLAND</div>					<div>Md.</div>				
<div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Perry Hall</div>					<div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>X Perry Hall (6)</div>				
<div>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</div> <div>4024 Klausmierz Rd.</div>					<div>d. STREET ADDRESS</div> <div>4024 Klausmierz Rd.</div>				
<div>3. NAME OF DECEASED (Type or print)</div> <div>William H. Krumholtz</div>					<div>4. DATE OF DEATH</div> <div>Jan. 10, 1962</div>				
<div>5. SEX</div> <div>Male</div>					<div>6. COLOR OR RACE</div> <div>White</div>				
<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>					<div>8. DATE OF BIRTH</div> <div>Aug. 28, 1888</div>				
<div>9. AGE (In years last birthday)</div> <div>73 yrs.</div>					<div>10. IF UNDER 1 YEAR</div> <div>Months 4 Days 12</div>				
<div>11. IF UNDER 24 HRS.</div> <div>Hours Min.</div>					<div>12. CITIZEN OF WHAT COUNTRY?</div>				
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Paper Cutter</div>					<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>J.E. Smith</div>				
<div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>Baltimore</div>					<div>12. CITIZEN OF WHAT COUNTRY?</div>				
<div>13. FATHER'S NAME</div> <div>Henry Krumholtz</div>					<div>14. MOTHER'S MAIDEN NAME</div> <div>Lottie Brown</div>				
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>no</div>					<div>16. SOCIAL SECURITY NO.</div> <div>216-05-4753</div>				
<div>17. INFORMANT</div> <div>Lillian E. Krumholtz</div>					<div>Address</div> <div>4024 Klausmierz Rd. Perry Hall, Balto.</div>				
<div>18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).)</div> <div>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</div> <div>Acute leukemia</div>					<div>19. INTERVAL BETWEEN ONSET AND DEATH</div>				
<div>20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div>					<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>				
<div>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>					<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div>				
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m. p.m.</div>					<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>				
<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>					<div>20f. (City or town) (County) (State)</div>				
<div>21. I certify that (I) (this hospital) attended the deceased from 13 Nov. 1961 to 10 Jan. 1962 that (I) (we) last saw the deceased alive on 5 Jan. 1962 and that death occurred at 3:05 A.M. from the causes and on the date stated above.</div>					<div>22a. SIGNATURE</div> <div>A.M. Renick</div>				
<div>22b. DATE SIGNED</div> <div>10 Jan 62</div>					<div>22c. PHYSICIAN'S NAME (Type)</div> <div>A.M. Renick</div>				
<div>22d. ADDRESS</div> <div>1101 St Paul Balt 2 md.</div>					<div>22e. ATTENDING PHYS.</div> <div>M.D. <input checked="" type="checkbox"/></div>				
<div>22f. MED. DIRECTOR <input type="checkbox"/></div>					<div>22g. STAFF PHYS. <input type="checkbox"/></div>				
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>					<div>23b. DATE THEREOF</div> <div>Jan. 13, 1962</div>				
<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Parkwood</div>					<div>23d. LOCATION (City, town or county) (State)</div> <div>Baltimore County</div>				
<div>24. FUNERAL DIRECTOR'S SIGNATURE</div> <div>Frederick A. Cole</div>					<div>25a. REC'D BY REGISTRAR</div> <div>JAN 11 '62</div>				
<div>25b. REGISTRAR'S SIGNATURE</div> <div>Arthur S. Kraw</div>					<div>25c. ADDRESS</div> <div>1913 W. Balto. St.</div>				





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00287

00284

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>605 NORTH BEND RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution's Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>605 NORTH BEND RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS JOSEPH LAMBERT SR.</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JULY 18, 1880</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.				4. DATE OF DEATH <u>JAN. 12 1962</u> Month Day Year			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OFFICE BLDG.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>MD</u>				13. FATHER'S NAME <u>PATRICK J. LAMBERT</u> 14. MOTHER'S MAIDEN NAME <u>MARY DOYLE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>THOMAS J. LAMBERT, JR - 605 NORTH BEND RD.</u> 17. INFORMANT <u>THOMAS J. LAMBERT, JR - 605 NORTH BEND RD.</u> Address				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pneumonia & Pulmonary edema</u> <u>493X</u> DUE TO <u>Bacterial Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5, 1962</u> to <u>1/12 1962</u> , that (I) (we) last saw the deceased alive on <u>1/12 1962</u> and that death occurred on <u>1/12 1962</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. J. Nolan</u> 22c. PHYSICIAN'S NAME (Type) <u>J. J. NOLAN</u>				22b. ADDRESS <u>1 Mallow Hill Ave Baltimore</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Forley, Carmichael, J.H. - Catonsville, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>1/13/62</u> 25b. REGISTRAR'S SIGNATURE <u>John S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7, 61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
00288			
00285			
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN TB <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6100 FREDERICK RD.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>6100 FREDERICK RD.</u>	
3. NAME OF <u>LOUISE H. LANDON</u> (Type or print)		4. DATE OF DEATH <u>JAN. 15, 1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 8, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES H. SCHLOSSER</u>		14. MOTHER'S MAIDEN NAME <u>SOPHIA GEBB</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes give year of entry and date of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MISS IRMA SCHLOSSER</u>		18. ADDRESS <u>6100 FREDERICK RD, CATONSVILLE 28 MD.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> (e), stating the underlying cause last (c) <u>1031</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-3-1962</u> to <u>1-15-1962</u> that (I) (we) last saw the deceased alive on <u>1-16-1962</u> and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wibner K. Gallager</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wibner K. Gallager M.D.</u>		22d. ADDRESS <u>6209 Frederick Ave. Baltimore 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/18/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMET.</u>		23d. LOCATION (City town or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE, 4101 EDMONDSON AVE.</u>		25a. REC'D BY REGISTRAR <u>JAN 18 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>C. H. & H. H.</u>			





Page 4
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00290

CERTIFICATE OF DEATH

00287

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8nth20dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 113 Academy Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) F rst Middle Last Carrie V. Lee			4 DATE OF DEATH Month Day Year January 23 1962		
5 SEX f. male	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 17, 1873		9 AGE (In years and birthday) 88 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U. S. A.					
13 FATHER'S NAME JAMES WESLEY LEE			14. MOTHER'S MAIDEN NAME MARY JACKSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16 SOCIAL SECURITY NO unknown		17. INFORMANT MR J. WALTER MUSTERMAN (2) Records: SPRING GROVE STATE HOSPITAL	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) SPRING GROVE STATE HOSPITAL	
		20f (City or town) Catonsville		(County) (State)	
21 I certify that (1) (this hospital) attended the deceased from May 3 11:20 1961 to Jan. 23 1962 that (1) (we) last saw the deceased alive on Jan. 23 1962 and that death occurred at 2 M. from the causes and on the date stated above					
22a SIGNATURE Stella Wachslar		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1-23-62	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 01-25-1962		23c NAME OF CEMETERY OR CREMATORY Mayo Memorial Cent	
		23d LOCATION (City, town, or county) Mayo		(State) Md	
24 FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		ADDRESS Annapolis, Md.		25a REC'D BY REGISTRAR DATE JAN 25 '62	
		25b. REGISTRAR'S SIGNATURE W. S. Kline			

(M)

(I)



MARYLAND STATE DEPARTMENT OF HEALTH

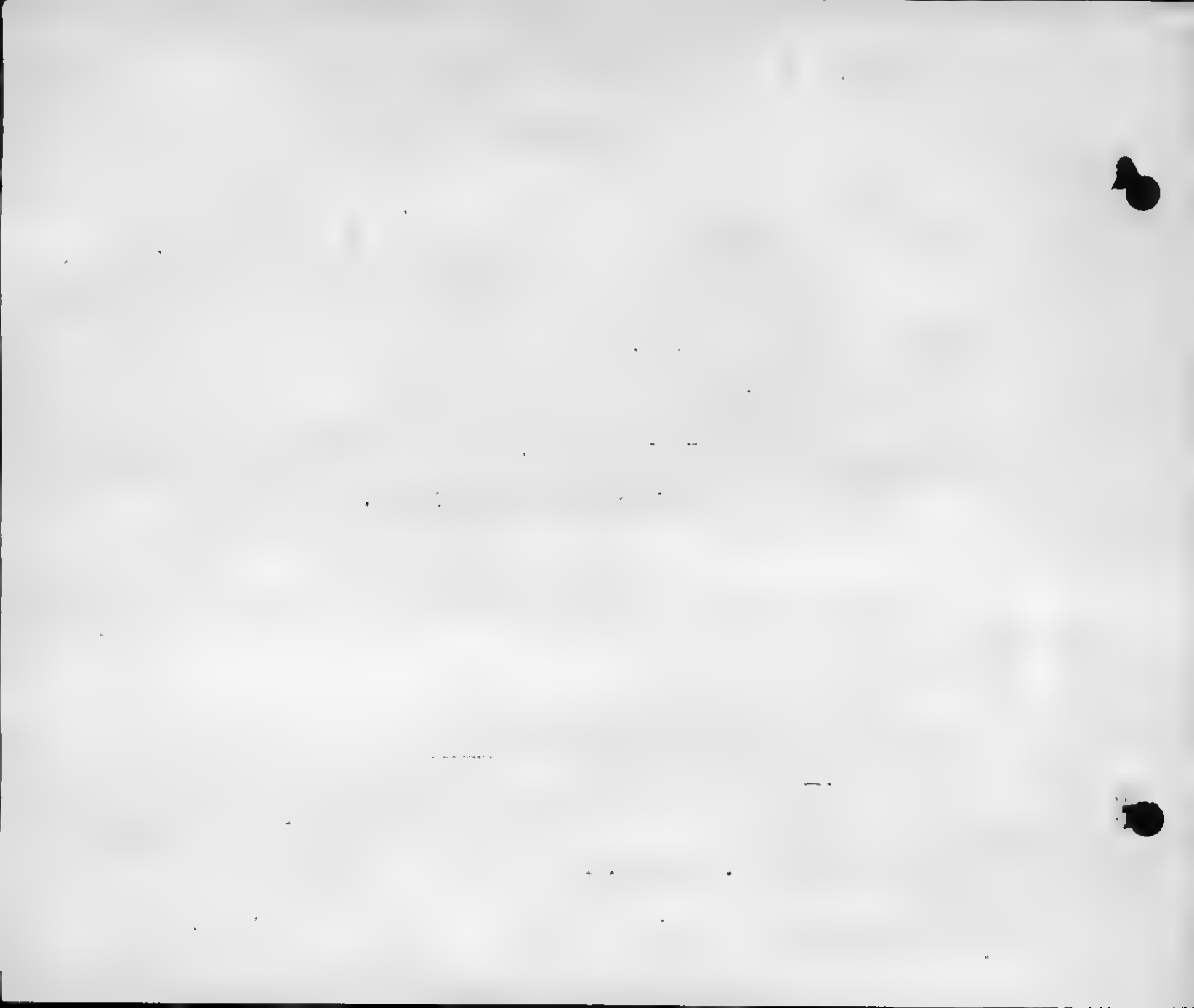
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any de-
cessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u> c. LENGTH OF STAY IN 1b <u> </u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sparrows Point Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u> </u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7246 Conley Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u> <u>LEMANTOWSKI</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb. 1, 1914</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>47</u> yrs.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Shipping</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>? Lemantowski</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>15-07-0214</u> 17. INFORMANT <u>Mrs. Lillian Lemantowski, 7246 Conley St.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease.</u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u> </u> 19 <u> </u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1/4/62</u>			
ACTUAL SIGNATURE <u>Charles S. Petty</u> EXAMINER'S NAME (Type) <u>Charles S. Petty, M.D.</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>1/8/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u> 22d. LOCATION (City, State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE</u>				24a. REC'D BY REGISTRAR <u>JAN 8 '62</u> 24b. REGISTRAR'S SIGNATURE <u> </u>			



TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301.W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00292

00289

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN b. <u>34 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Grasonville</u> d. STREET ADDRESS <u>F7 Chester River Drive</u>	
3. NAME OF DECEASED (Type or print) <u>James H. Letts</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 20, 1905</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		9b. AGE (In years last birthday) <u>56 yrs.</u>	
10a. KIND OF BUSINESS OR INDUSTRY <u>Crown, Cork & Seal</u>		10b. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
11. FATHER'S NAME <u>Walter Letts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Anna Bailey</u>		14. SOCIAL SECURITY NO. <u>216-01-7053</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. INFORMANT <u>Clinical records, VAH, Baltimore, Maryland - Ft. Howard Division</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VALVULAR HEART DISEASE, AORTIC AND MITRAL INSUFFICIENCY, CHRONIC, RHEUMATIC, DECOMPENSATED</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO <u>410 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		18. INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH, IF EITHER, NOTIFY MEDICAL EXAMINER. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>1</u> p.m. <u>1</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from November 28, 1961, to January 1, 1962, that (b) (we) last saw the deceased alive on January 1, 1962, and that death occurred at 1:00 a.m. on the causes and on the date stated above.			
22a. SIGNATURE <u>Walter J. Wampler, Jr., M.D.</u>		22b. DATE SIGNED <u>1/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter J. Wampler, Jr., M.D.</u>		22d. ADDRESS <u>VAH, BALTO. MD. FT. HOWARD DIV.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BAL</u>		23b. DATE THEREOF <u>1/3/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE 28, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight Inc.</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. Cook-Blight Inc.</u>		25c. ADDRESS <u>6009 Harford Rd. Balto 11, Md.</u>	

VR A15 (4)
15M 9/60



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 201 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00293

CERTIFICATE OF DEATH

Item 2 Film G-0n 2/4/62 iwk

00290

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY (in days)

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

House-in-the-Pines, 16 Fusting Ave.

3. NAME OF

(Type or print)

Helen

Lewis

5 SEX

female

6. CO. OR RACE

white

7. MARRIED

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

1895

9 AGE (in years last birthday)

66 6/11

IF UNDER 1 YEAR: Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired broker

10b. KIND OF BUSINESS OR INDUSTRY

real estate

11 BIRTHPLACE (County & State, or foreign country)

Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Frank Deuterman

14. MOTHER'S M maiden name

Catherine Kahlert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO

579-30-9566

17. INFORMANT

Mrs. Catherine Miller-New Market, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

Acute Pulmonary Edema

18a. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

Arteriosclerotic Cardio Vascular Disease

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 10-31-1961 to 1-30-1962 that (I) (we) last saw the deceased alive on 1-30-1962, and that death occurred at 9:45 A.M. from the causes and on the date stated above.

22. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

Wilmer K. Gallagher, MD

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

6209 Frederick Ave. Balt. 28 Md

22b. DATE SIGNED

1-30-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

burial

23b. DATE THEREOF

Feb. 2, 1962

23c. NAME OF CEMETERY OR CREMATORY

Cedar Hill

23d. LOCATION (City, town or county)

Suitland, Md.

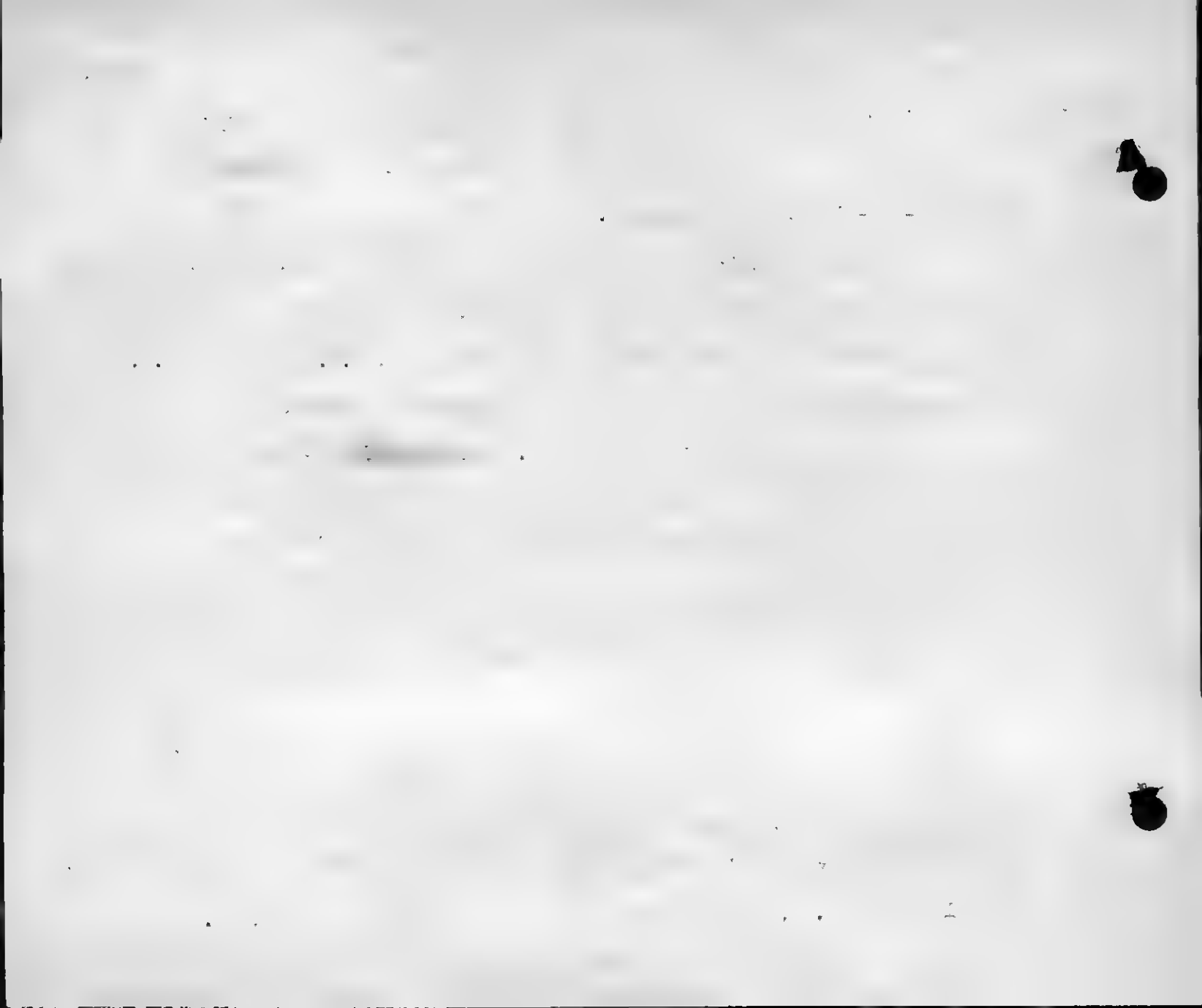
24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Wilmer K. Gallagher, 2901 14th NW, WASH DC FEB 1 1962



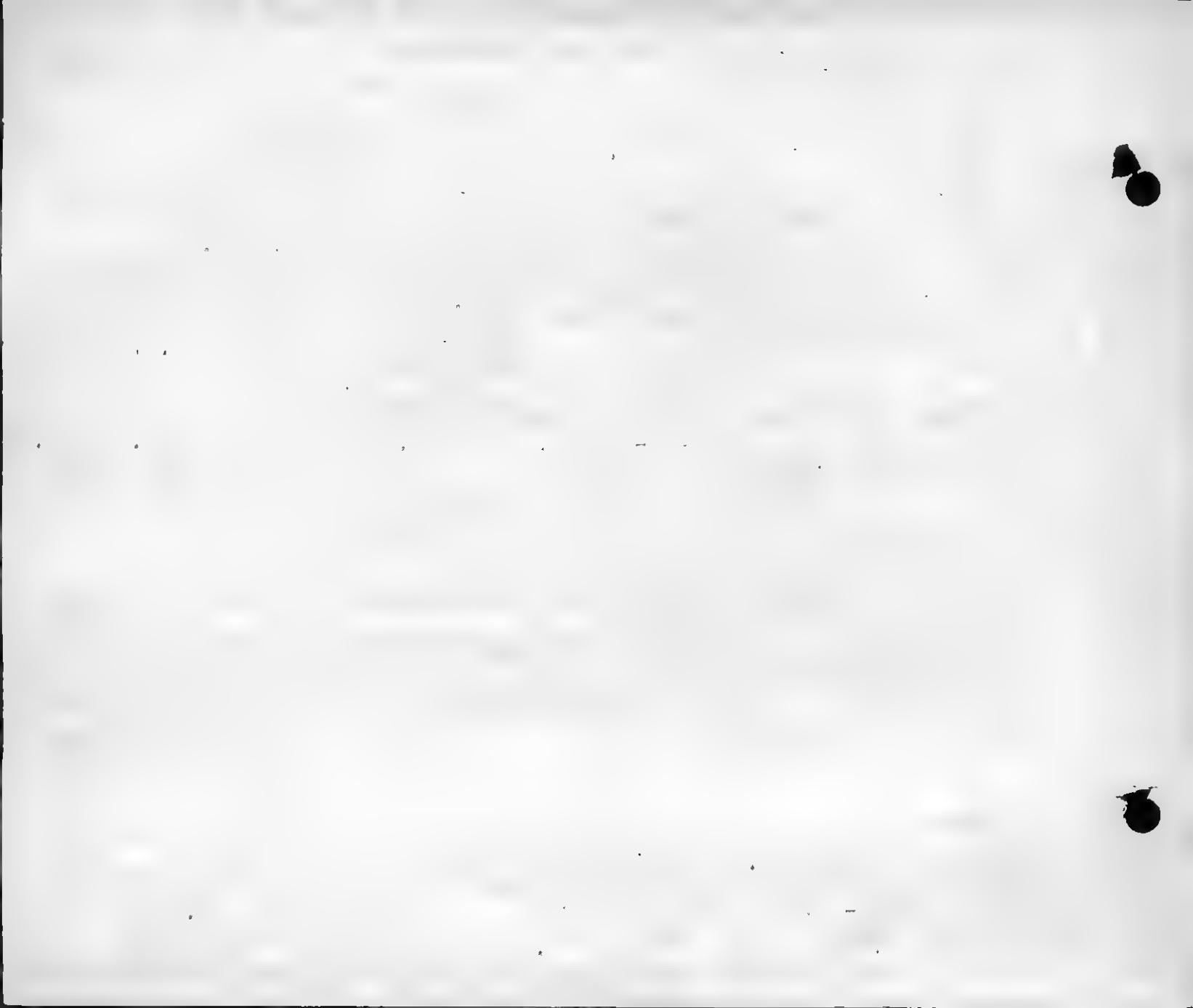
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00291

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 Elmore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ida Middle Gross Last Luthy		4. DATE OF DEATH Jan, 26, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1892
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Gross		14. MOTHER'S MAIDEN NAME Marthea Litzau	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-20-942	
17. INFORMANT Mrs. Ardith J. Hood		Address Owings Mills, 109 Elmore Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis - acute DUE TO 27.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Chronic DUE TO (c) Emphysema - Chronic		INTERVAL BETWEEN ONSET AND DEATH Immediate Years Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September, 1958 , to January 26, 1962 , that I last saw the deceased alive on January 15, 1962 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence E. McWilliams		ADDRESS (Street, city or town, state) 11904 Rockstone Rd. Rockstone, Md.	
PHYSICIAN'S NAME (Type) Clarence E. McWilliams		DATE SIGNED Jan 27, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30, 1962	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		ADDRESS Pikesville, Md.	
24a. REC'D BY REGISTRAR JAN 30 '62		24b. REGISTRAR'S SIGNATURE Clarence E. McWilliams	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
00295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00292

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7835 KENTLEY RD. ZONE 22</u>		d. STREET ADDRESS <u>7835 KENTLEY RD ZONE 22</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD JOSEPH MADIGAN</u>		4. DATE OF DEATH Month Day Year <u>JAN 18 1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/26/1932</u>
9. AGE (in years last birthday) <u>29</u> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TURN FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETH. STEEL</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>EDWARD J. MADIGAN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH WEBER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-30-2708</u>	
17. INFORMANT <u>MARLENE SPARKS MADIGAN, WIFE, ABOVE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUN-SHOT wound of Abdomen</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>12 Gauge Shot Gun</u> (c) <u>shot</u> DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18) <u>Shot Self in Abdomen</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10:15</u> <u>PM</u>	20d. INJURY OCCURRED Where at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. City or town (County) (State) <u>DUNDALK BALTIMORE MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>[Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/22/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>SCHIMMUNK FUNERAL HOME INC.</u>		24a. REC'D BY REGISTRAR <u>[Signature]</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>JAN 23 '62</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director or to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

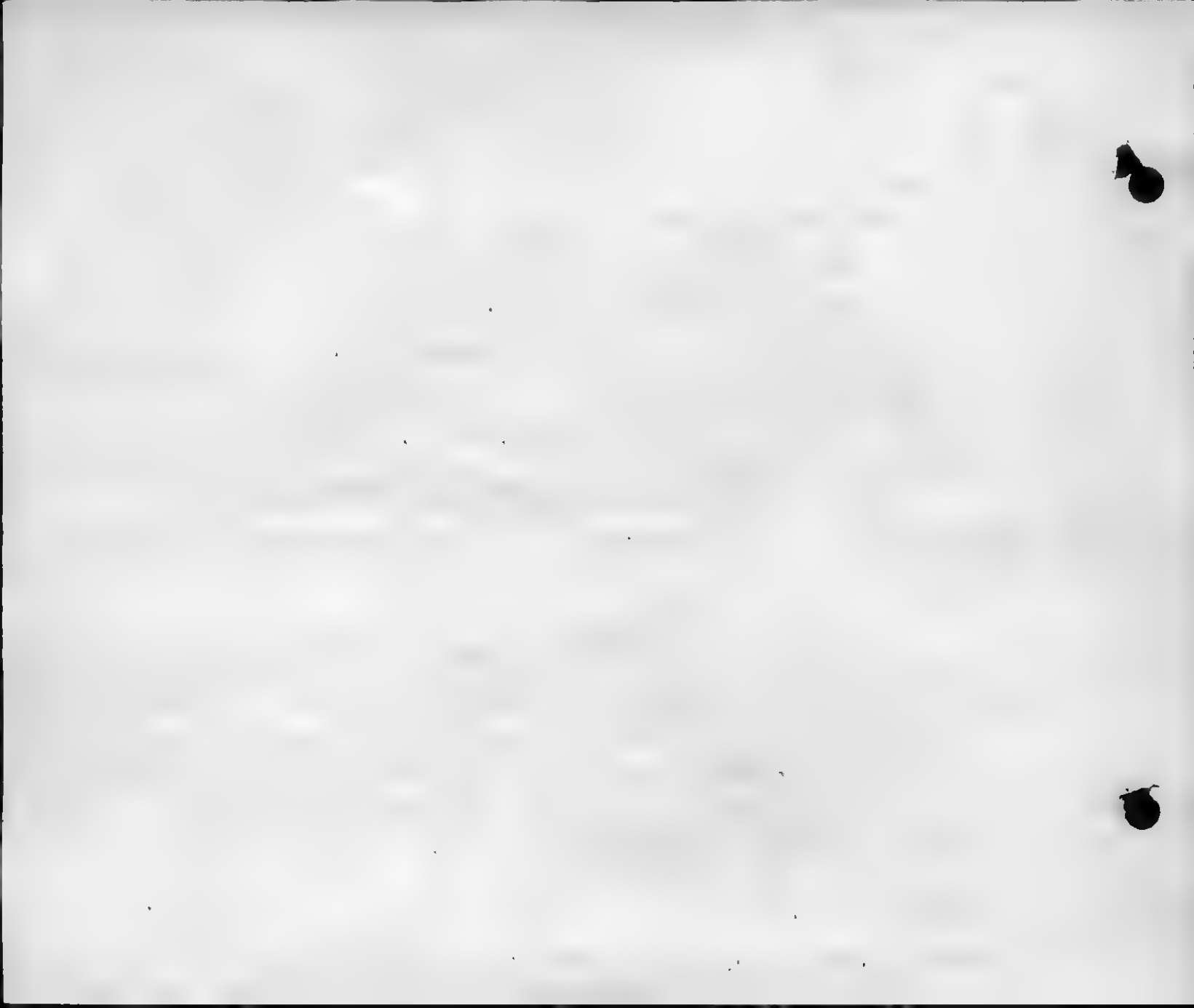


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00296
00293
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Men</u>		4. DATE OF DEATH <u>Jan 20 1962</u>	
5. SEX <u>Female</u>		9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS.) Last birthday Months Days Hours Min. <u>80 yrs</u>	
6. COLOR OR RACE <u>White</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/>		11. PLACE OF BIRTH <u>Portland, Me.</u>	
13. FATHER'S NAME <u>James Macdonald</u>		14. MOTHER'S MAIDEN NAME <u>Mary Gillan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS. (Men) Macann 300 Woodbourne Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Metastatic From</u> <u>Pancreas To Liver</u> Conditions, if any, which gave rise to immediate cause (b) <u>6 Months</u> (c) <u>6 Months</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 27, 1961</u> to <u>Jan 20, 1962</u> , that (I) <u>(X)</u> last saw the deceased alive on <u>Jan 20, 1962</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.		22b. DATE SIGNED <u>1/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		22d. ADDRESS <u>2501 York Rd. Towson #4 Me.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 24, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem</u>		23d. LOCATION (City, town or county) (State) <u>Portland Me.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Kuck, Inc.</u>		24b. ADDRESS <u>5505 Hartford Rd.</u>	
25a. REC'D BY REGISTRAR <u>JAN 24 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles F. O'Donnell</u>	



00294

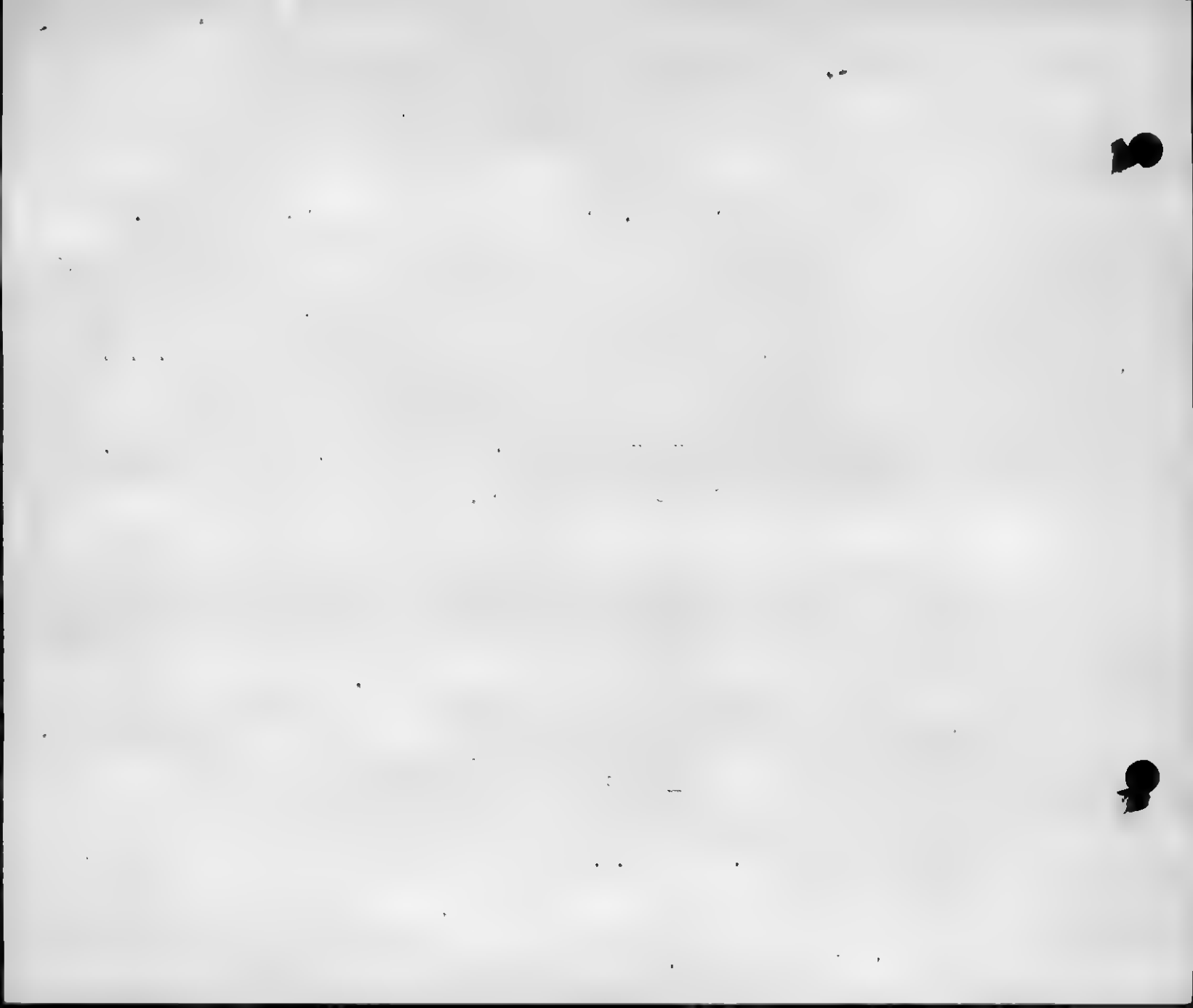
Order

VR A35 (4)
15M 9/60



VS. A1SME
SM 9,60

18 Jan



sary,
 Page
 files
 health

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before adm ssion) a. STATE N.Y. b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TROY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 36 DUBLIN DRIVE		e. STREET ADDRESS 1713 HIGHLAND AVE.	
3. NAME OF DECEASED (Type or print) MARY ALICE McGRANE		4. DATE OF DEATH Month JAN Day 4 Year 1962	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		12. BIRTHPLACE (State or foreign country) N.Y.	
13. CITIZEN OF WHAT COUNTRY? USA		14. FATHER'S NAME JAMES SCARRY	
15. MOTHER'S MAIDEN NAME ELLEN KELLY		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT MRS. ELLEN WIDMAYER, 36 DUBLIN DRIVE	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 MIN. 20 YRS.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) TOWSON, MD.			
DATE SIGNED 1-4-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial/Removal			
22b. DATE THEREOF Jan. 8, 1962			
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery			
22d. LOCATION (City, town, or country) (State) Troy, New York -			
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.			
24a. REC'D BY REGISTRAR DATE JAN 8 '62			
24b. REGISTRAR'S SIGNATURE James S. [Signature]			



1
FOR STATE
HEALTH DEPT.

00300

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00297

Item 7 Film G306 4/9/62

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ATLANTA</u> <u>(PAKISTAN)</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Isaac</u>		4. DATE OF DEATH <u>1 - 17 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Separated</u>		8. DATE OF BIRTH <u>5-27-1906</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>3rd. Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship</u>	
11. BIRTHPLACE (State or foreign country) <u>Honeyhill, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>Elsie McKenzie?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W.#2</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sis. Monroe Records, POINE Md.</u>		Address <u>SPARROWS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>420</u> IMMEDIATE CAUSE (a) <u>CURRY ARY (C.C. H.S. 1)</u> DUE TO (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part I of item 18] <u>ATX</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Spec. 4) <u>Removal</u>		22b. DATE THEREOF <u>2-4-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Schulerville, S. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Randolph J. Collick</u>		24b. REGISTRAR'S SIGNATURE <u>7/7/62</u>	
ADDRESS <u>1412 E. Preston St.</u>		DATED <u>5 '62</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

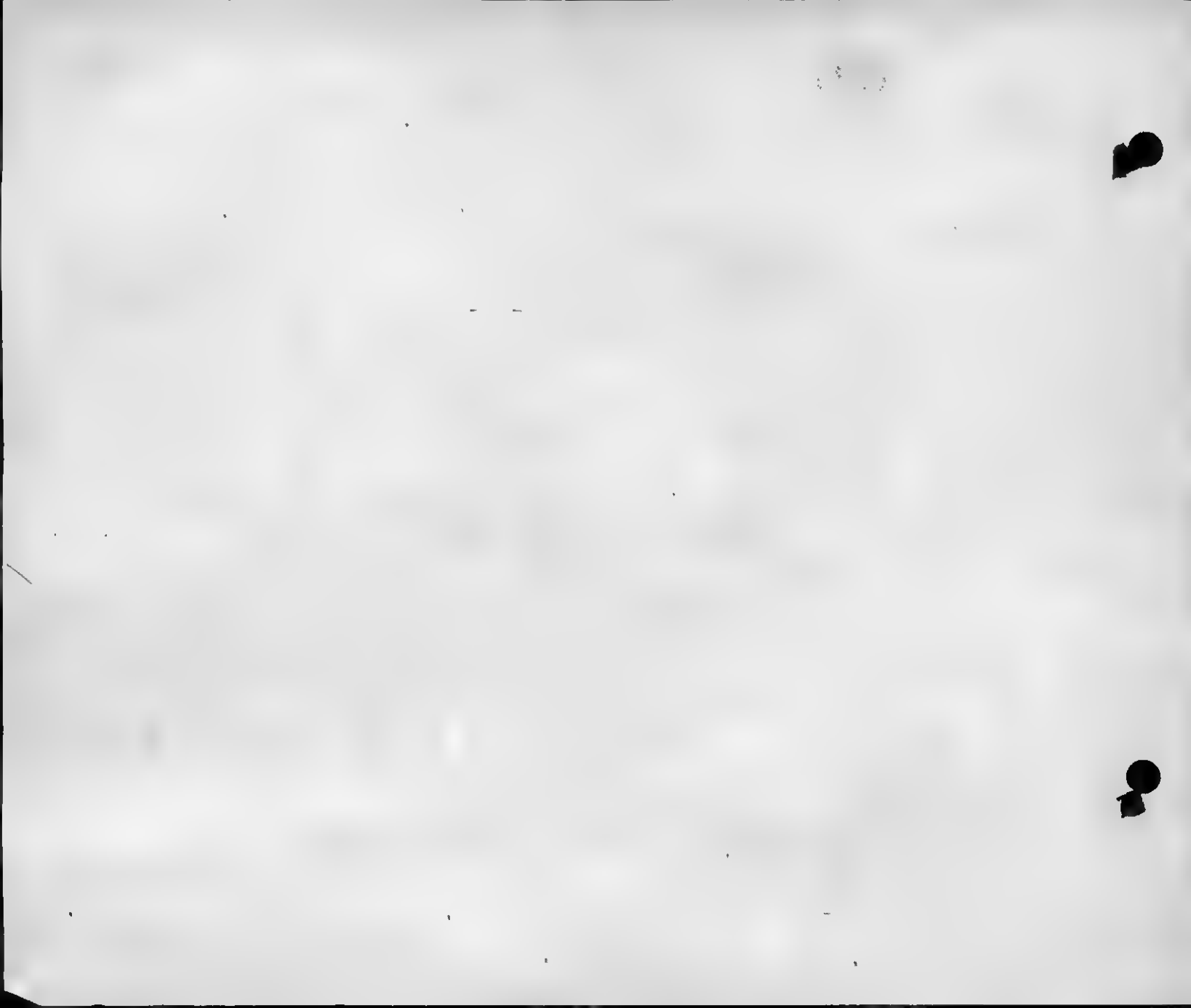
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00301

00298

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>6-1+</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1421 Clairidge Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Genevieve T. McKew</u> First Middle Last 4. DATE OF DEATH <u>1</u> <u>25</u> <u>1962</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-16-1883</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>62</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> 11. CITIZENSHIP (County & State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Luke McKew</u> 14. MOTHER'S MAIDEN NAME <u>Harriet Olson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Miss Angela West</u> 16. SOCIAL SECURITY NO. <u>same</u> 17. INFORMANT <u>same</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE & ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> CONDITIONS, if any, which gave rise to immediate cause (b) <u>3 yrs</u> (a), stating the underlying cause last. (c) <u>3 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> to <u>1/25</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/24</u> , 19 <u>62</u> and that death occurred at <u>12:30</u> M. from the causes and on the date stated above. 22a. SIGNATURE <u>Thos E Roach</u> 22b. DATE SIGNED <u>1/25</u> 22c. PHYSICIAN'S NAME (Type) <u>Thos E Roach</u> 22d. ADDRESS <u>5350 Bardo Mart Pike - 28</u> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>1-29-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u> 25a. REC'D BY REGISTRAR <u>JAN 29 '62</u> DATE <u>28</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00299

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Dundalk (22)

c. LENGTH OF STAY IN 1b

6 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

7203 Dungen Court

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Dundalk (22)

d. STREET ADDRESS

7203 Dungen Court

a. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First Bassill

Middle Guy

Last McVey

4. DATE OF DEATH

Month

Day

Year

January 12th 1962

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

Feb. 18, 1910

9. AGE (in years last birthday)

51 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Welder Inspector

10b. KIND OF BUSINESS OR INDUSTRY

Steel

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Martin D. McVey

14. MOTHER'S MAIDEN NAME

Adda Terry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

no

16. SOCIAL SECURITY NO.

135-10-4038

17. INFORMANT

Mrs. Anna T. McVey

Address

same as #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

CORONARY OCCLUSION

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

None

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Melvin B. Davis

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

1/13/62

EXAMINER'S NAME (Type)

Melvin B. Davis, M.D.

Dundalk 22 Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/15/62

22c. NAME OF CEMETERY OR CREMATORY

Gardens of Faith

22d. LOCATION (City, town, or country)

Baltimore Co., Maryland

23. FUNERAL DIRECTOR

Walter Brooks Bradley, Inc., Dundalk 22, Md.

24a. REC'D BY REGISTRAR

JAN 16 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00303

00300

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Baltimore, Maryland</u>		c. LENGTH OF STAY IN 1b <u>20 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>518 Oakley St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Messick</u> Last <u>Messick</u>				4. DATE OF DEATH Month <u>1</u> Day <u>10</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/4/00</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Messick</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Hubock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>		16. SOCIAL SECURITY NO. <u>214-07-9966</u>		17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>IC3X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>For Adv. Pul TB (Tuberculosis)</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> <u>1961</u> to <u>1/10</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>1/10</u> <u>1962</u> , and that death occurred at <u>4:55</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>W. Newman</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/10/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. Newman, M.D., Superintendent</u>				22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/13/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				25a. RECORDING REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



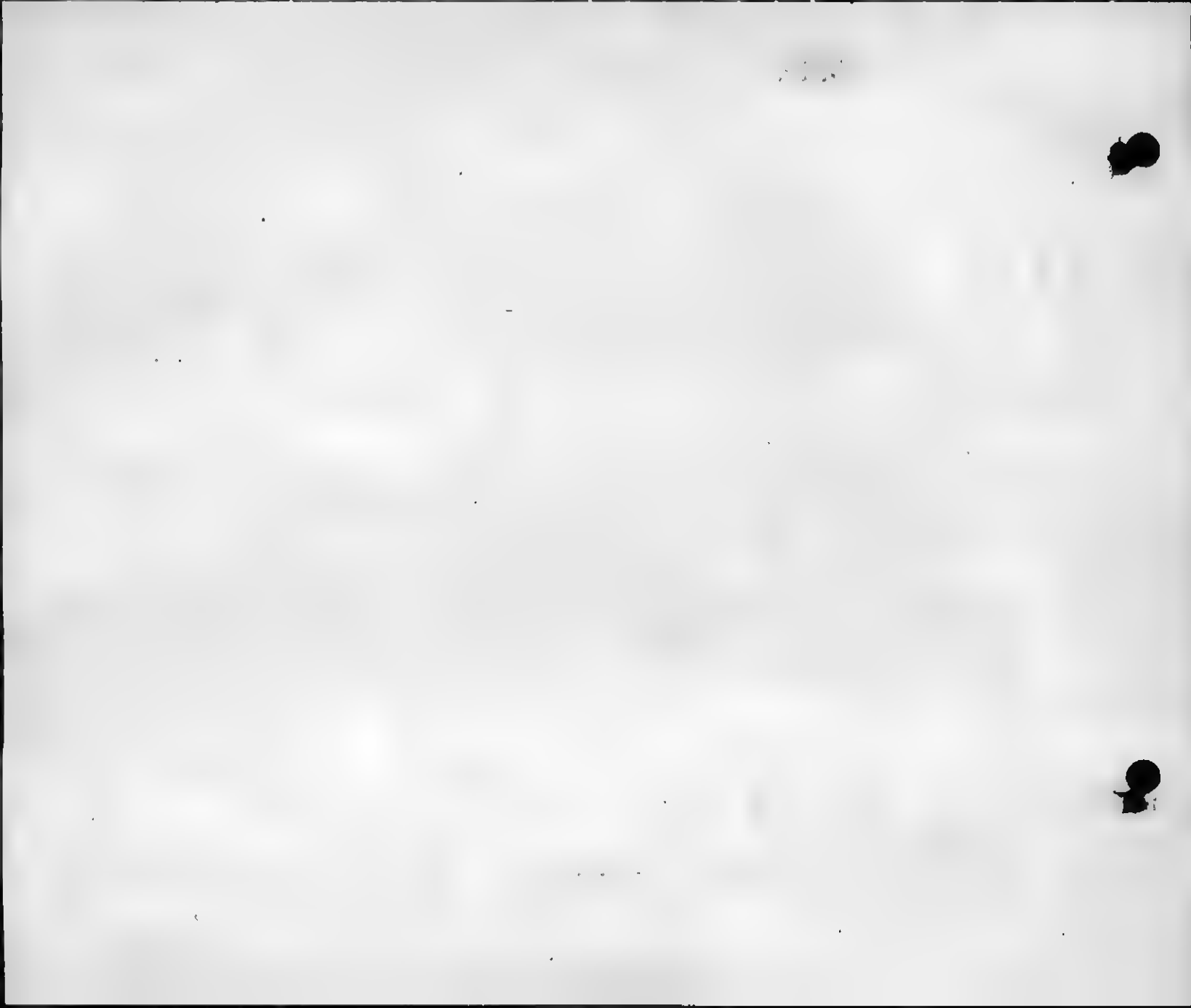
TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00304 CERTIFICATE OF DEATH 00301

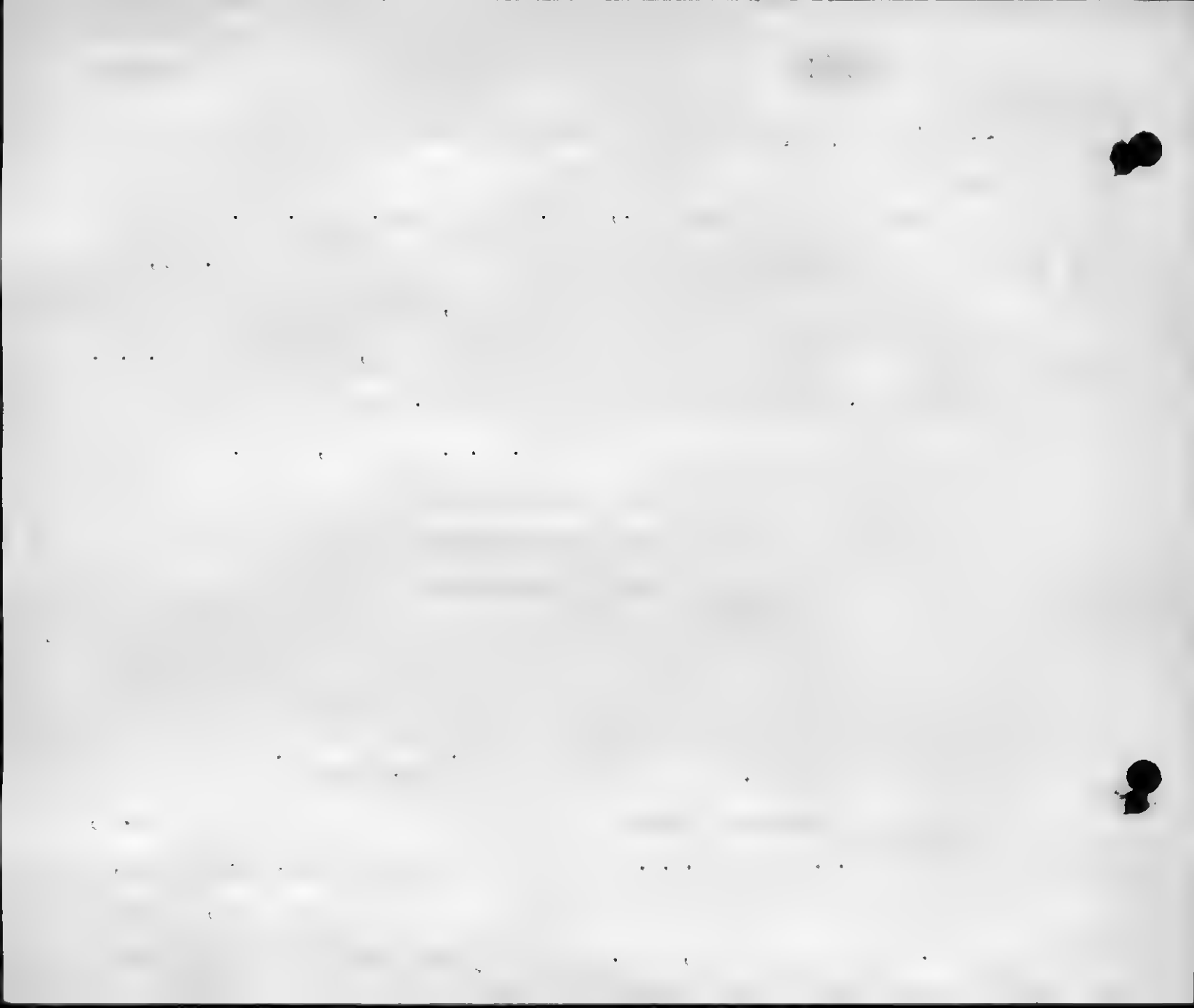
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not at time of death, residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier	
c. LENGTH OF STAY IN b. 4 years		d. STREET ADDRESS 3401 Bunker Hill Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital			
3. NAME OF DECEASED (Type or print) Hugo Meyer			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 11-9-81	9. AGE (in years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josef Meyer		14. MOTHER'S MAIDEN NAME Elisabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give year or dates of service) yes World War I			
16. SOCIAL SECURITY NO. INFORMANT Address			
17. RECORDS: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovalvular disease years Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis years (c) due to			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/3/58 to 1/31/62 , 19... that (I) (we) last saw the deceased alive on 1/31/62 , 19... and that death occurred at 8:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 1/31/62	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS Spring Grove State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/2/62	23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	23d. LOCATION (City, town or county) (State) Falls Church, Va.
24. FUNERAL DIRECTOR'S SIGNATURE F. Marchis Soria		25. REC'D BY REGISTRAR 2/2/62	
ADDRESS 4139 Balt Av, Hyattsville, Md		25b. REGISTRAR'S SIGNATURE William S. Frank	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 72 hours after death. Page 4 is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div>1</div> <div>00305</div> <div>Item 1, 111 111 - 1, 111 111 mmb</div> <div>00302</div>											
<div>1</div> <div>PLACE OF DEATH</div> <div>a. COUNTY</div>						<div>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</div> <div>e. STATE</div> <div>b. COUNTY</div>					
Baltimore						Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN (b)					
Towson						Years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
Presbyterian Home of Md., Inc.						315 E. 22nd. St.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Charlotte Miller						Jan. 19, 1962					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		May 11, 1876		184 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						11. BIRTHPLACE (County & State, or foreign country)					
Retired						Westernport, Maryland					
12. CITIZEN OF WHAT COUNTRY?						U.S.A.					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Joseph M. Miller						Sarah C. Schrader					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.					
No						17. INFORMANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						Address					
PART I. DEATH WAS CAUSED BY:						Mrs. T.E. Elliott, Supt. Presbyterian Home of Maryland					
IMMEDIATE CAUSE (a)						Cerebral thrombosis					
1143 DUE TO						INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						3 weeks					
(b)						years					
DUE TO						years					
(c)						years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED?					
Pernicious anemia						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)					
20c. TIME OF INJURY						20d. INJURY OCCURRED					
Month, Day, Year						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
Hour a.m. p.m.						20f. (City or town) (County) (State)					
19						While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (the hospital) attended the deceased from Jan. 1, 1958, to Jan. 19, 1962, that (I) (we) last saw the deceased alive on Jan. 17, 1962, and that death occurred at 9:40 am from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED					
S.J. Venable, Jr. M.D.						Jan. 19, 1962					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
S.J. Venable, Jr. M.D.						7215 York Road, Baltimore 12, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF					
Burial						1-22-62					
23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City, town or county) (State)					
Druid Ridge						Likesville, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE						25a. REC'D BY REGISTRAR					
John O. Mitchell & Sons, Inc.						25b. REGISTRAR'S SIGNATURE					
1900 Eutaw Place, 17						DATE JAN 22 '62					



00306

CERTIFICATE OF DEATH

Reg. Dist. No.

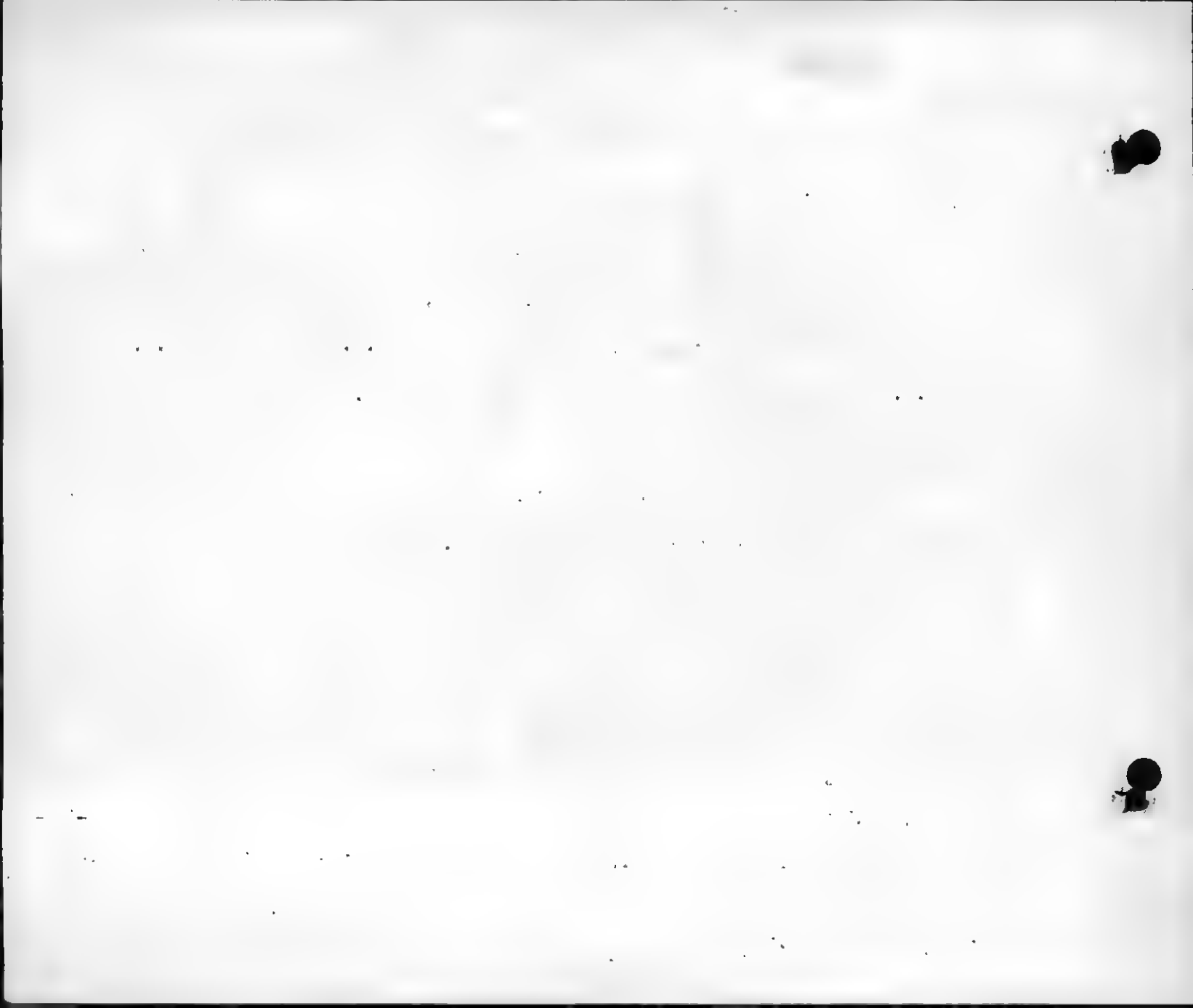
00303

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>Dent Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Mitchell</u> Last <u>Mitchell</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1906</u>	
9. AGE (In years last birthday) <u>55</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Freeman N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laos</u>			
13. FATHER'S NAME <u>W.S. Mitchell</u>				14. MOTHER'S MAIDEN NAME <u>Suzie M. Spaulding</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		INFORMANT <u>Irene Mitchell</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic C. V. Disease</u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>7</u> days <u> </u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>January 12, 1962</u> to <u>January 27, 1962</u> , that I last saw the deceased alive on <u>January 26, 1962</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>48 Main Street</u> DATE SIGNED <u>1-27-62</u> ACTUAL SIGNATURE <u>Martin E. Strobel</u> M.D. <u> </u> PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u> <u>Reisterstown</u> <u>Baltimore</u> <u>Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Freeman Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Freeman N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. O. Wilson</u>		ADDRESS <u>1030</u> <u>Sanitary Ave</u>		24a. REC'D BY REGISTRAR <u>JAN 31 1962</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

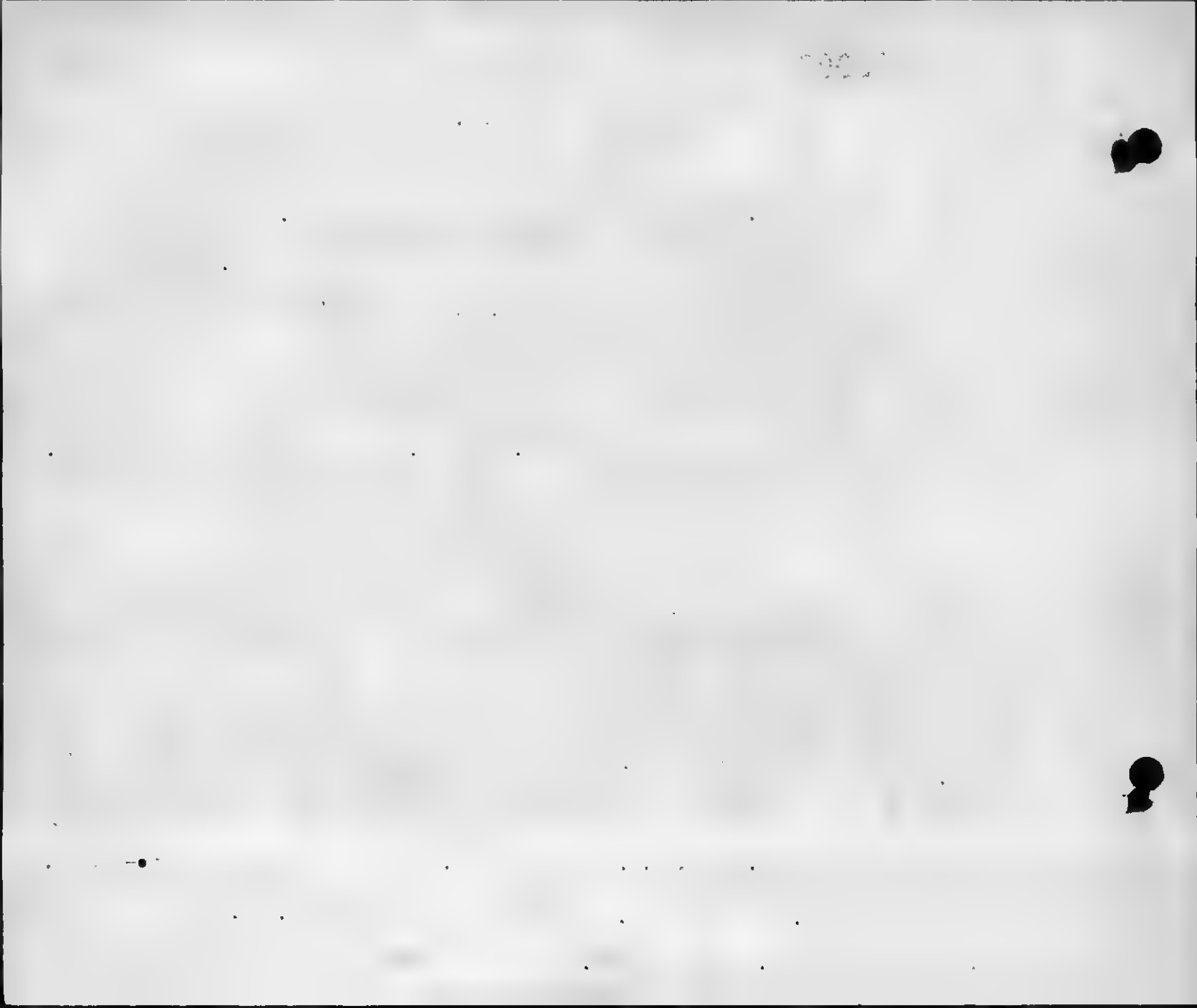
VS A15 (4)
15M 9/58



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
00307		00304	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	e. STATE	f. COUNTY
Maryland	Baltimore	Md.	12
c. LENGTH OF STAY (In days)	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	f. STREET ADDRESS
12	7104 Sheffield Rd.	Baltimore	7104 Sheffield Rd.
3. NAME OF DECEASED (Type or print)	4. DATE OF DEATH	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Euphonia	Jan. 13 1962		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
F	W		Jan. 9, 1885
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
77 yrs.	Housewife	Scotland	Scotland
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
Daniel Weir	Mary Colville	None	
16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
	Mrs. Alice M. Pettigrew	7104 Sheffield Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		10 mos.	
150 X DUE TO			
Conditions, if any, which gave rise to immediate cause (b)			
(e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Severe Hypertension & coronary artery disease			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY (Month, Day, Year)	20d. INJURY OCCURRED (While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>)	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
Hour a.m. p.m. 19			
21. I certify that (I) (this hospital) attended the deceased from 10 to 12:59 P.M. on Jan 12 1962, that (I) saw the deceased alive on 175 1962, and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE	22b. PHYSICIAN'S NAME (Type)	22c. M.D.	22d. ADDRESS
William F. Fritz	William F. Fritz, M.D.		2 W. University parkway, Balt-18, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY
Removal	Jan. 16 1962	Geo. Washington Mem Park	Phil. Pal
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
J. A. Cook-Townson, Inc.	1950 York Rd.	DATE JAN 16 '62	Charles E. Hume



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY **Baltimore** MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Catonsville**
c. LENGTH OF STAY IN b **3yr5mth25dys**
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **SPRING GROVE STATE HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Baltimore**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Baltimore**
d. STREET ADDRESS **6717 Youngstown Avenue**

3. NAME OF DECEASED (Type or print)
First **Gaetano** Middle **Modo** Last **Modo**

4. DATE OF DEATH **JANUARY 12 1962**
Month **January** Day **12** Year **1962**

5. SEX **male** 6. COLOR OR RACE **white** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **1980 February 81**
9. AGE (In years last birthday) **81** yrs. Months **12** Days **12** Hours **12** Min. **12**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **ice cream vendor** 10b. KIND OF BUSINESS OR INDUSTRY **Maryland** 11. BIRTHPLACE (State or foreign country) **Maryland** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

13. FATHER'S NAME **Benny Modo** 14. MOTHER'S MAIDEN NAME **Philomina Pilato**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **unknown** 16. SOCIAL SECURITY NO. **216-22-3952** 17. INFORMANT **SPRING GROVE STATE HOSPITAL**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Acute coronary occlusion**
Conditions, if any, which gave rise to immediate cause (b) **coronary arteriosclerosis**
(c) **generalized arteriosclerosis**
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I - **fracture left hip, chronic brain syndrome due to cerebral arteriosclerosis**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. EXTERNAL CAUSE WAS PRIMARY (1) OR CONTRIBUTING CAUSE OF DEATH. **X** 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) **On 11-3-61 pt. was struck by another patient, causing him to fall to the floor sustaining subcapital frac. of left femur.**

20c. TIME OF INJURY Month, Day, Year **11-3-61** 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **hospital** 20f. City or town, (County) (State) **Catonsville 28, Maryland**

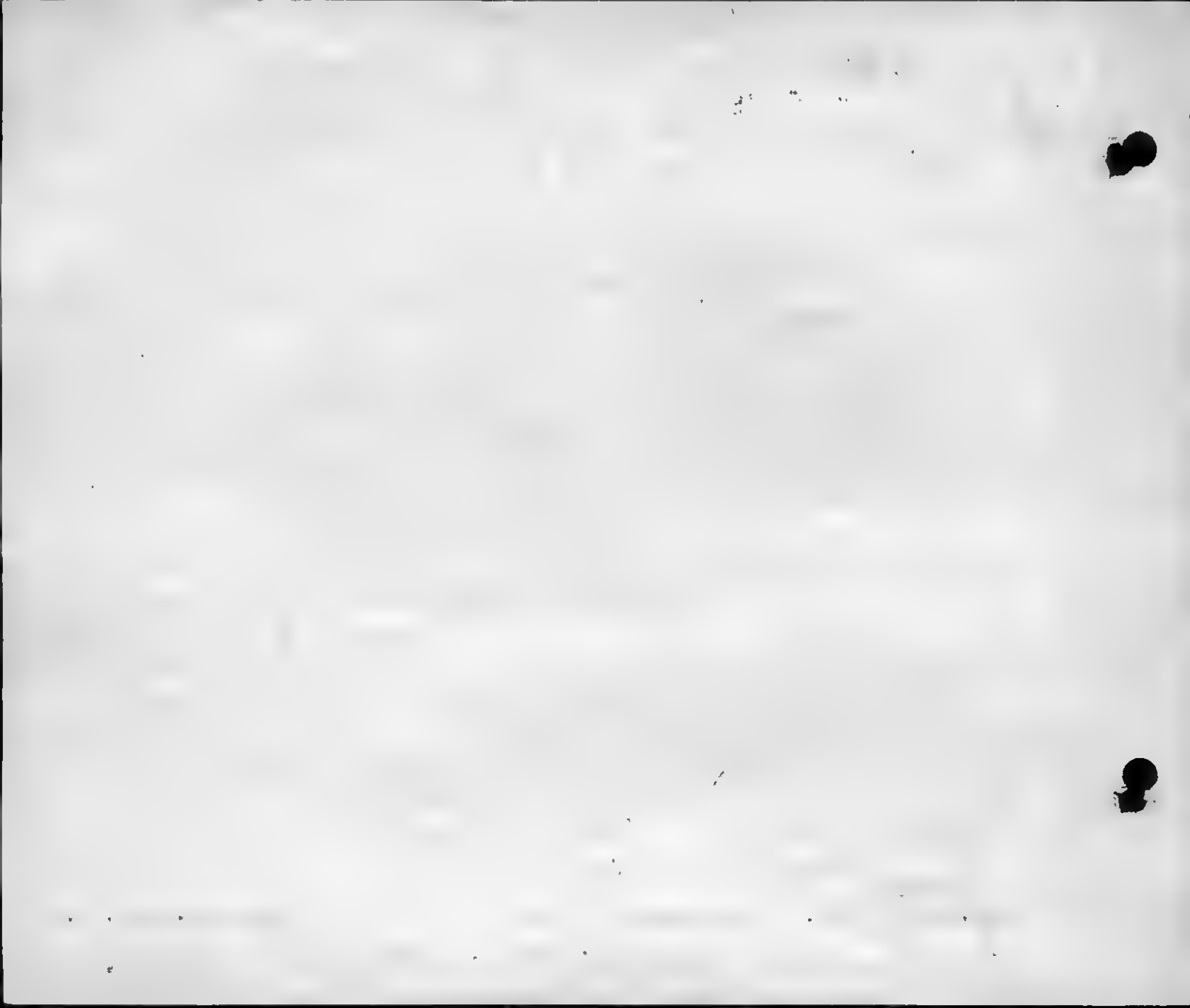
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

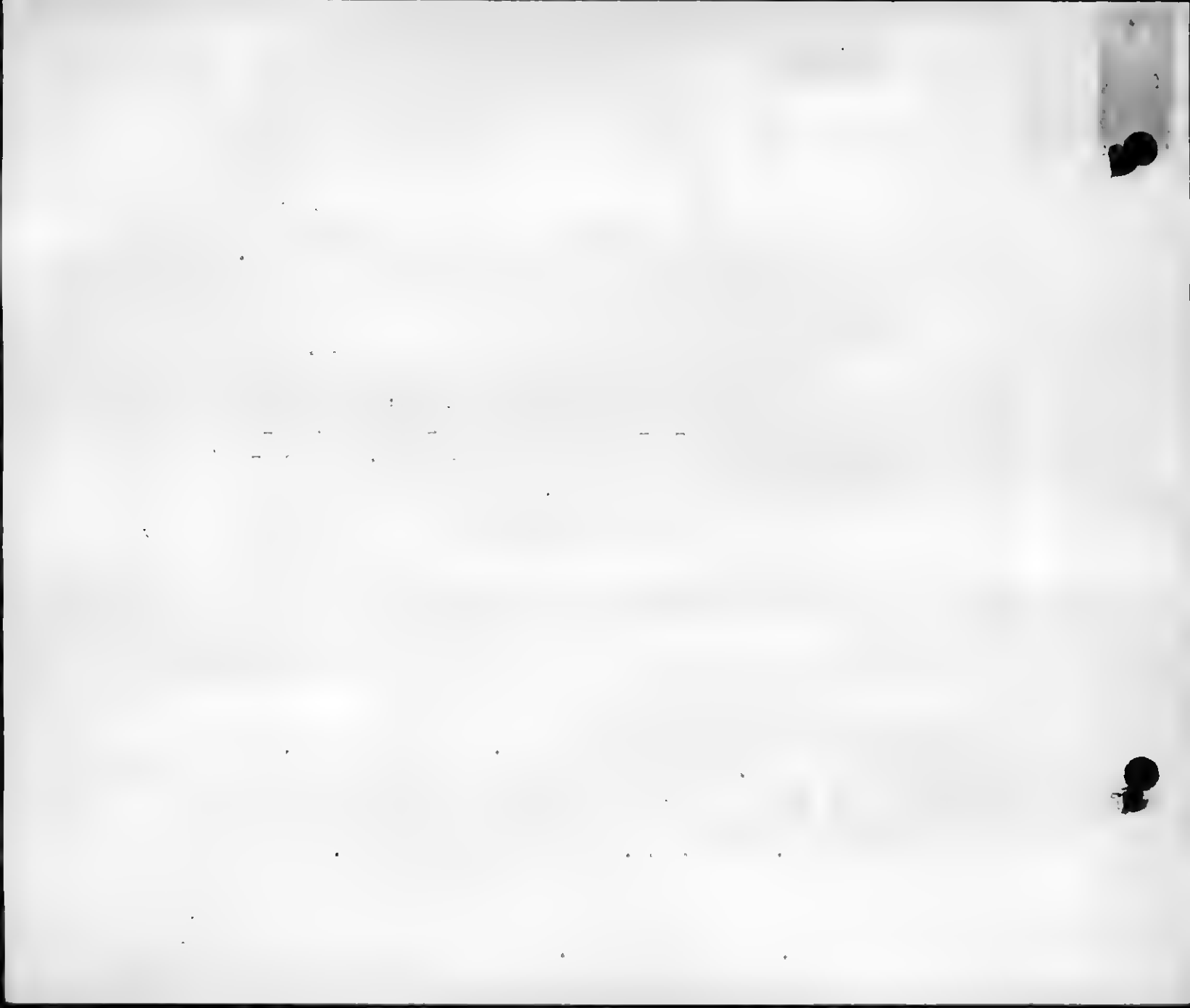
ACTUAL SIGNATURE **Joseph R. Gladue** M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) **Joseph R. Gladue, D.M.D.** ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **1/11/62**
Address (Street, city, town, or county) **322 S. High St.**

22a. BURIAL, CREMATION, 22b. DATE THEREOF **Jan. 4 1962** 22c. NAME OF CEMETERY OR CREMATORY **Gardens of Faith** 22d. LOCATION (City, town, or country) (State) **Trump & Mill Rd. Balt. Md.**

23. GENERAL DIRECTOR **Frank Della Noce** 24a. REC'D BY REGISTRAR **JAN 4 '62** 24b. REGISTRAR'S SIGNATURE **Frank Della Noce**

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay in execution, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

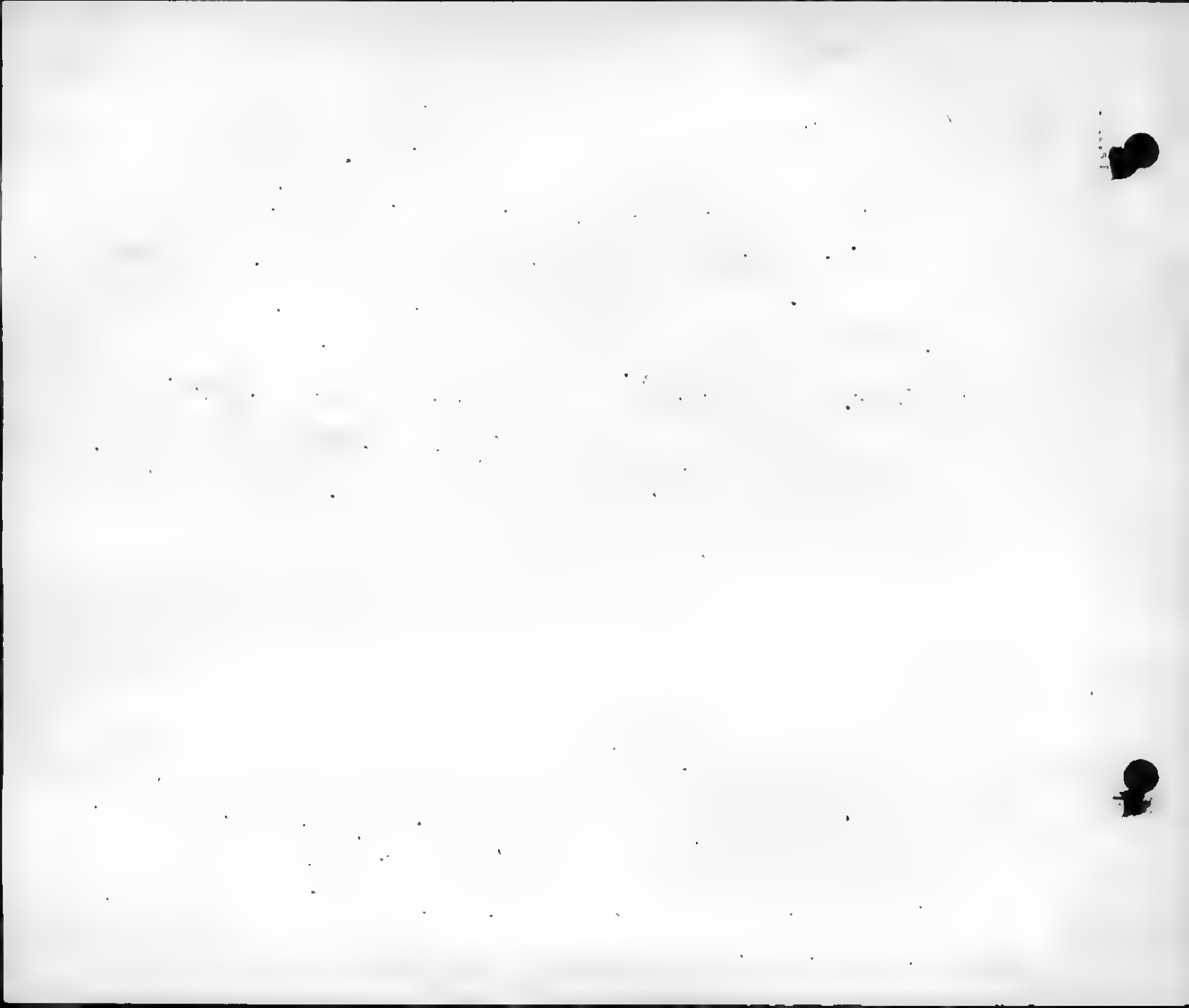




CERTIFICATE OF DEATH

Reg. Dist. No. 00307

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Old River		c. LENGTH OF STAY IN 1b 9 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3114	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ADAMSBURG LUTHERAN HOME				d. STREET ADDRESS 268 N. Walton St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First MARY Middle LOUISA Last MUHLY				4. DATE OF DEATH Month Jan Day 19 Year 1962			
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 28, 1867	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE in years (last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
13. FATHER'S NAME HERMAN MUHLY				14. MOTHER'S MAIDEN NAME ELIZABETH BAUER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT T. W. Katerkamp Address 6811 CAMPBELL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Arterio Sclerotic Heart Disease 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (2) - Gynge DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs 2 wks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 55 , to Jan , 19 62 that I last saw the deceased alive on Jan , 19 62 , and that death occurred at 11:45 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4108 Liberty Hts Balto - Md DATE SIGNED 1-19-62 ACTUAL SIGNATURE Earl L. Chambers M.D. 4108 Liberty Hts Balto Md PHYSICIAN'S NAME (Type) Earl L. Chambers 4108 Liberty Hts Balto Md							
22a. DATE OF CREMATION Feb 12/62		22c. NAME OF CEMETERY OR CREMATORY Immortal Care		22d. LOCATION (City, town, or county) (State) Baltimore			
23. FUNERAL DIRECTOR'S SIGNATURE G. Seemann		ADDRESS 6067 Harbor		24a. REC'D BY REGISTRAR Ed		24b. REGISTRAR'S SIGNATURE W. S. Pinner	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

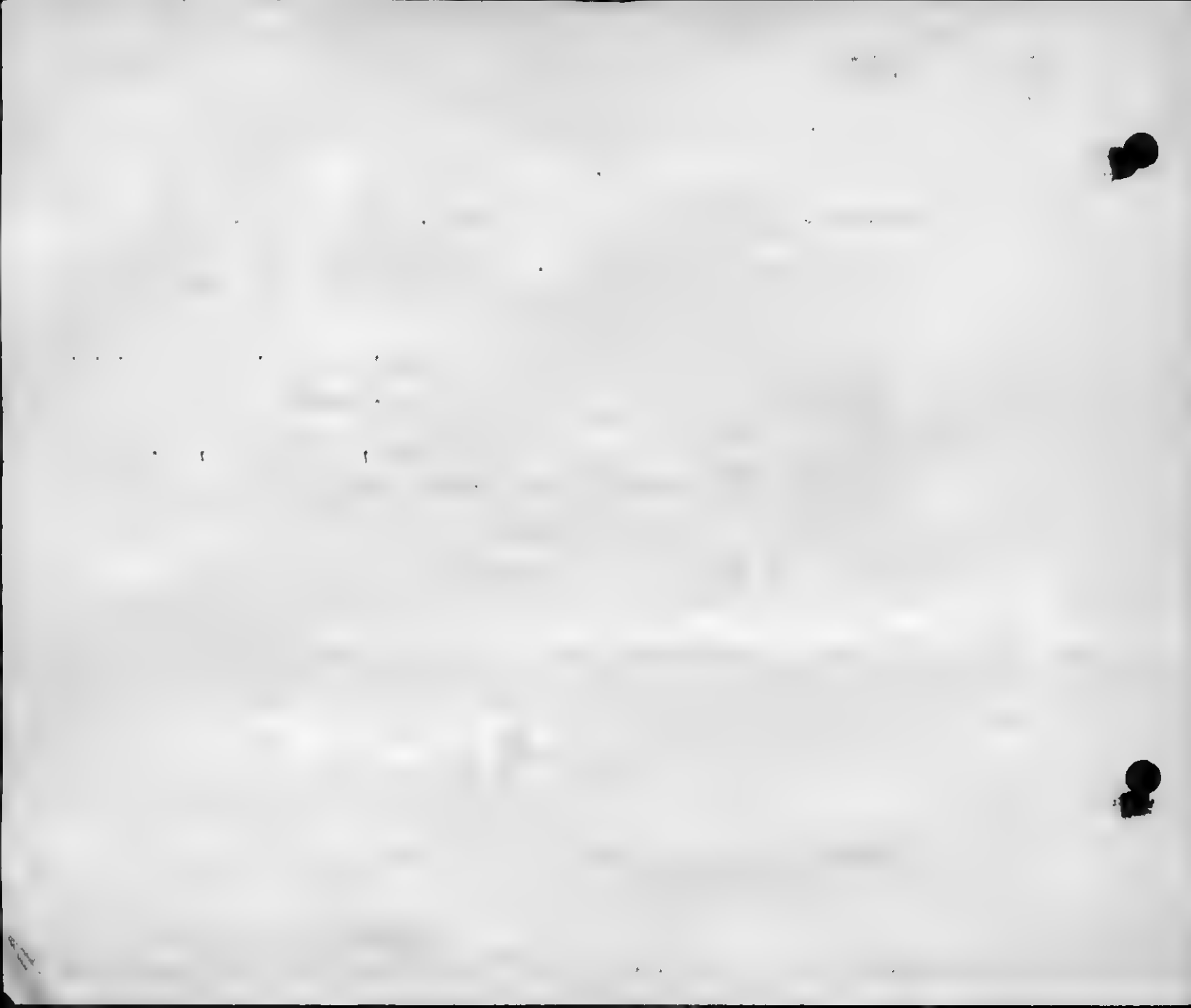
CERTIFICATE OF DEATH

00311

00308

M

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 5 yrs.		d. STREET ADDRESS 3401-4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Edward, Jr. NAIL		4. DATE OF DEATH Month 1 Day 21 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/6/55	
9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Days Hours Min. 6 yrs.		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11b. KIND OF BUSINESS OR INDUSTRY none	
12. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Charles Edward Nail		15. MOTHER'S MAIDEN NAME Lillian M. BLUMENSTOCK	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO none	
18. INFORMANT Rosewood Records, Owings Mills, Md.		19. ADDRESS Rosewood Records, Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 753.1 DUE TO Microcephalie Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cerebral dysgenesis (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 19, 1962 to Jan. 21, 1962 , that (I) (we) last saw the deceased alive on Jan. 21, 1962 , and that death occurred at 12:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Ernest I. Decko		22b. DATE SIGNED 1/21/62	
22c. PHYSICIAN'S NAME (Type) ERNEST I. DECKO		22d. ADDRESS ROSEWOOD ST. IN BALTO.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/24/62	
23c. NAME OF CEMETERY OR CREMATORY BALTO. NAT. CEM.		23d. LOCATION (City, town or county) (State) BALTO., MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Wiley Miller - 2334 Jefferson St.		25a. REC'D BY REGISTRAR JAN 24 1962	
ADDRESS		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

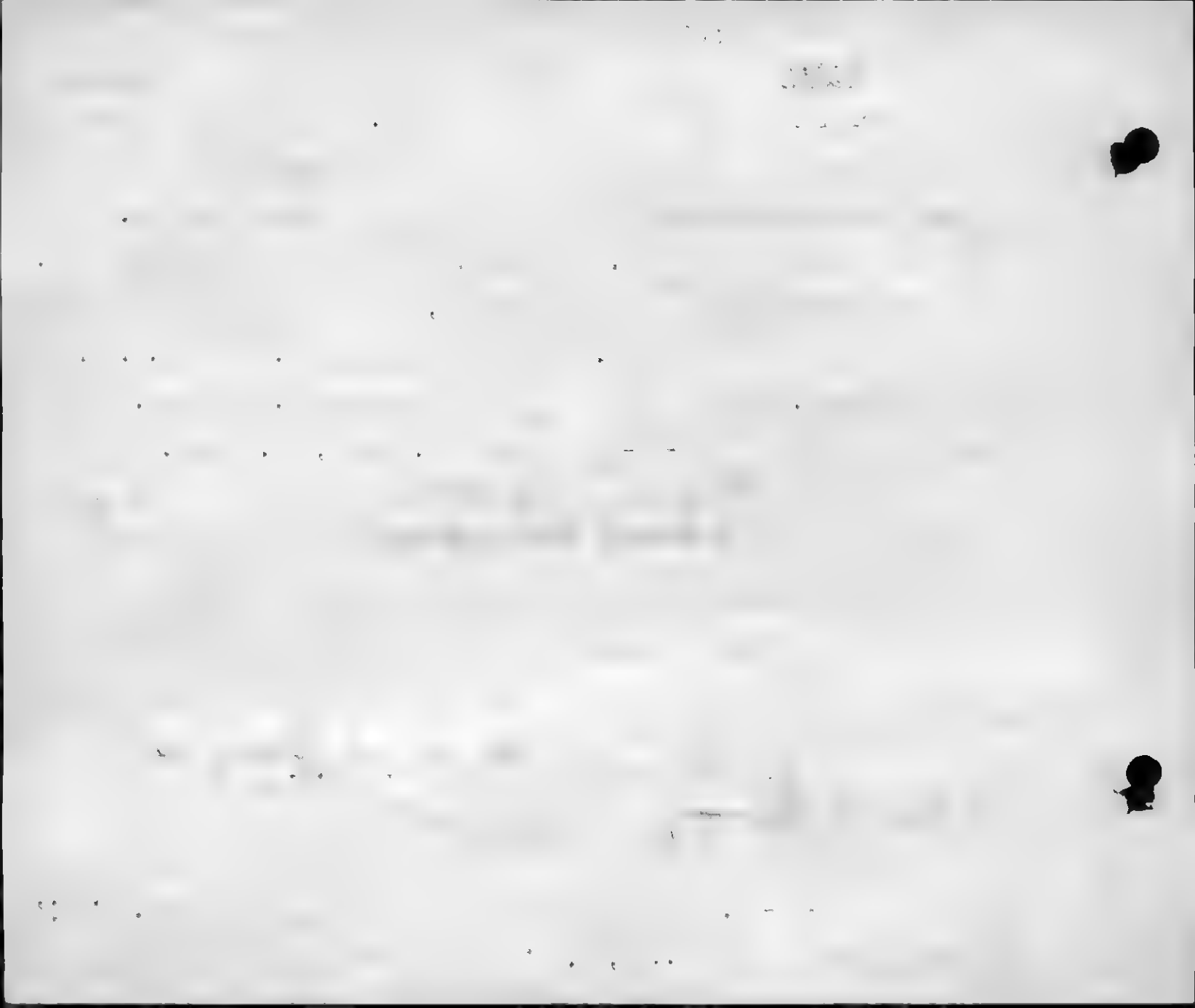
00312

00309

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2515 Lodge Forest Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lodge Forest d. STREET ADDRESS 2515 Lodge Forest Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print, First Middle Last) ANNA E. NANTZ.		4. DATE OF DEATH Month Day Year January 24, 1962.	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1905 9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work 10b. KIND OF BUSINESS OR INDUSTRY At Home. 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William H. Rice		14. MOTHER'S MAIDEN NAME Florence C. Vollerdt.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 216-20-9114 17. INFORMANT Thomas W. Nantz, Sr. Same. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus 174X DUE TO Conditions, if any, which gave rise to immediate cause (b) Internal hemorrhage (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH 3 years 1 hour	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office b dg., etc.)		20f. (City or town, County, State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 10, 1958 to Jan 24, 1962 that (I) (we) last saw the deceased alive on Jan 23, 1962 and that death occurred at 2:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John V. Conway 22c. PHYSICIAN'S NAME (Type) JOHN V. CONWAY		22b. DATE SIGNED M.D. D ST. SPARROWS POINT, MD. 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-27-62.		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 23d. LOCATION (City, town or county) 7225 Eastern Blvd. Ba. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Juler ADDRESS 6224 Eastern Ave. Balto., Md.		25a. REC'D BY REGISTRAR Jan 29 1962 25b. REGISTRAR'S SIGNATURE Thos. J. Harris	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

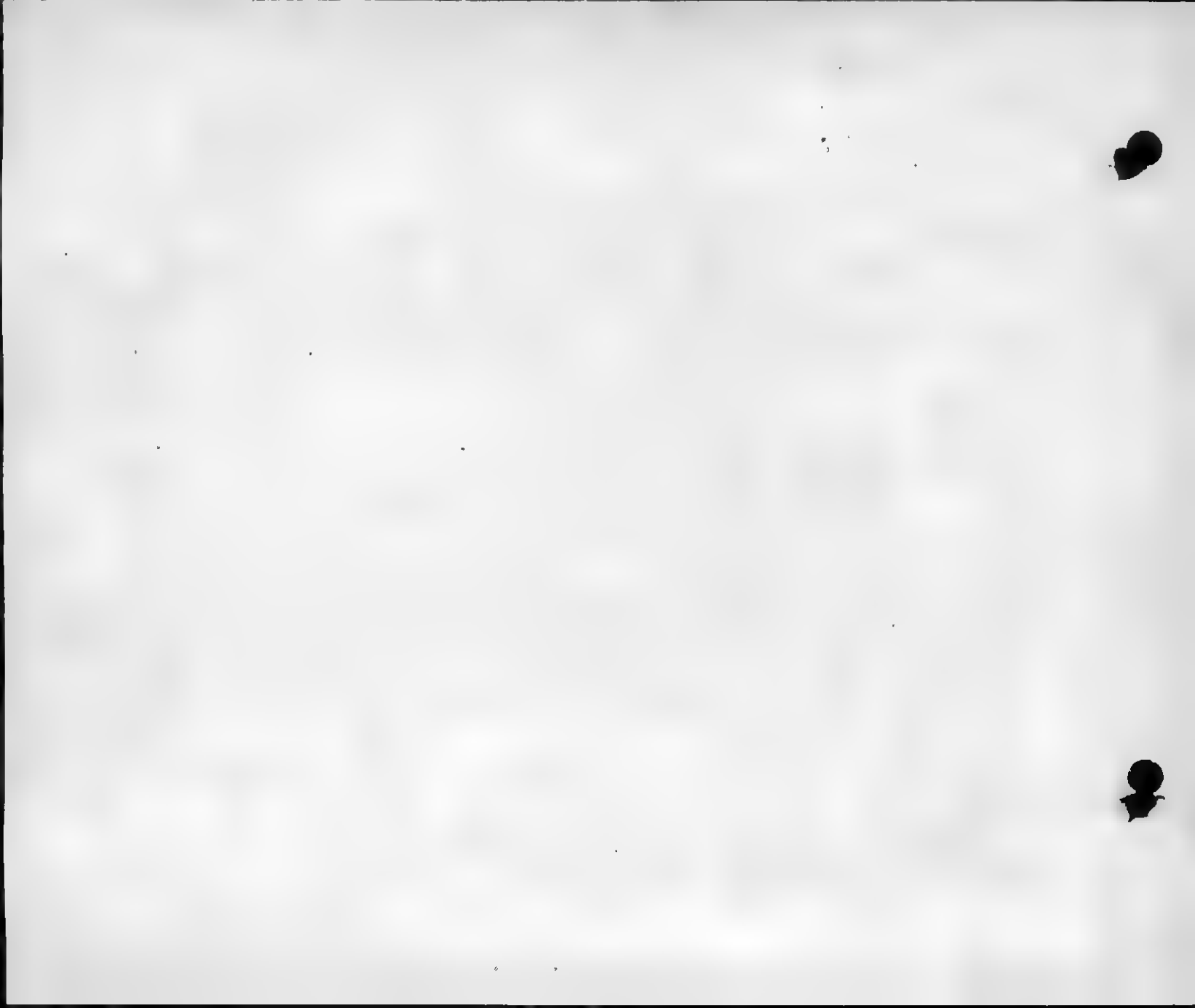
00310

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Jefferson</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turner Station</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>206 Avondale Road</u>				d. STREET ADDRESS <u>206 Avondale Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leonard</u> First <u>Newton</u> Middle Last				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1924</u>		9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Twp Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Red Springs, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Newton</u>				14. MOTHER'S MAIDEN NAME <u>Barbara McGulley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>219-12-8463</u>		17. INFORMANT Address <u>Lenora C. Newton - 206 Avondale Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420-</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 Min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Ave., Balto., Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 16 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Lawrence E. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00314

CERTIFICATE OF DEATH

00311

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural RANDALLSTOWN</u> c. LENGTH OF STAY IN 1b <u>Lite</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holbrook, Liberty Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - RANDALLSTOWN</u> d. STREET ADDRESS <u>Holbrook Liberty Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Walter HAVILAND O'Dell</u>	4. DATE OF DEATH <u>JAN. 16, 1962</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1879</u>	9. AGE (In years last birthday) <u>82</u> yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vault Mfg.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vaults</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Richard O'Dell</u>		14. MOTHER'S MAIDEN NAME <u>Emily Haviland</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u>		
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thromboses</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Arteriosclerosis</u> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Interval between onset and death 1/2 hr</u>		17. INTERVIEW WITH ONSET AND DEATH <u>1/2 hr</u>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS A TAPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>1/16/62</u> , 1962, that (I) (we) last saw the deceased alive on <u>1/16/62</u> , 1962, and that death occurred at <u>10A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Wm. E. Martin</u> M.D.		
22b. ADDRESS <u>Randallstown, Md</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Baltimore County - Md.</u>		22e. DATE SIGNED <u>JAN 22 '62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-19-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore County - Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Luther H. Haight</u>		24b. ADDRESS <u>Sykesville, Md</u>		25a. REC'D BY REGISTRAR <u>JAN 22 '62</u>		25b. REGISTRAR'S SIGNATURE <u>J. H. Haight</u>		



TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY **Baltimore**
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Fort Howard**
c. LENGTH OF STAY IN IL **22 Days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Veterans Administration Hospital**

3. NAME OF DECEASED
(Type or print) First Middle Last
WILLIAM K. OSBORNE
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Laborer** 10b. KIND OF BUSINESS OR INDUSTRY **Farming**

13. FATHER'S NAME **Josh Osborne** 14. MOTHER'S MAIDEN NAME **Nancy Farmer**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes** 16. SOCIAL SECURITY NO **215-12-0509**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **CARCINOMA OF STOMACH WITH METASTASIS**
DUE TO **1-1X**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **DUE TO** (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) **1. Emphysema of lungs. 2. Arteriosclerosis, generalized.**

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐

21. I certify that ☒ (this hospital) attended the deceased from **December 27, 1961** to **January 18, 1962**, that ☒ (we) last saw the deceased alive on **January 18, 1962**, and that death occurred at **4:50 A.M.** from the causes and on the date stated above.

22a. SIGNATURE **Joseph M. Miller** M.D. 22b. DATE SIGNED **1/18/62**
22c. PHYSICIAN'S NAME (Type) **JOSEPH M. MILLER, M.D.**
Chief, Surgical Service

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **1/20/1962** 23c. NAME OF CEMETERY OR CREMATORY **Memorial Gardens Demetery**

24. FUNERAL DIRECTOR'S SIGNATURE **Charles E. Kurtz** ADDRESS **Kurtz & Son Funeral Home, Jarrettsville, Md.**

2. USUAL RESIDENCE (Where deceased lived, if not in home; Residence before admission)
a. STATE **Maryland** b. COUNTY **Harford**
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Fallston**
d. STREET ADDRESS

4. DATE OF DEATH Month Day Year **January 18 19 62**
5. AGE (In years, last birthday) **70** yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (County & State, or foreign country) **Grayson Co., Virginia** 12. CITIZEN OF WHAT COUNTRY? **U. S. A.**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
INTERVAL BETWEEN ONSET AND DEATH **UNKNOWN**

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

20g. (City or town) (County) (State)

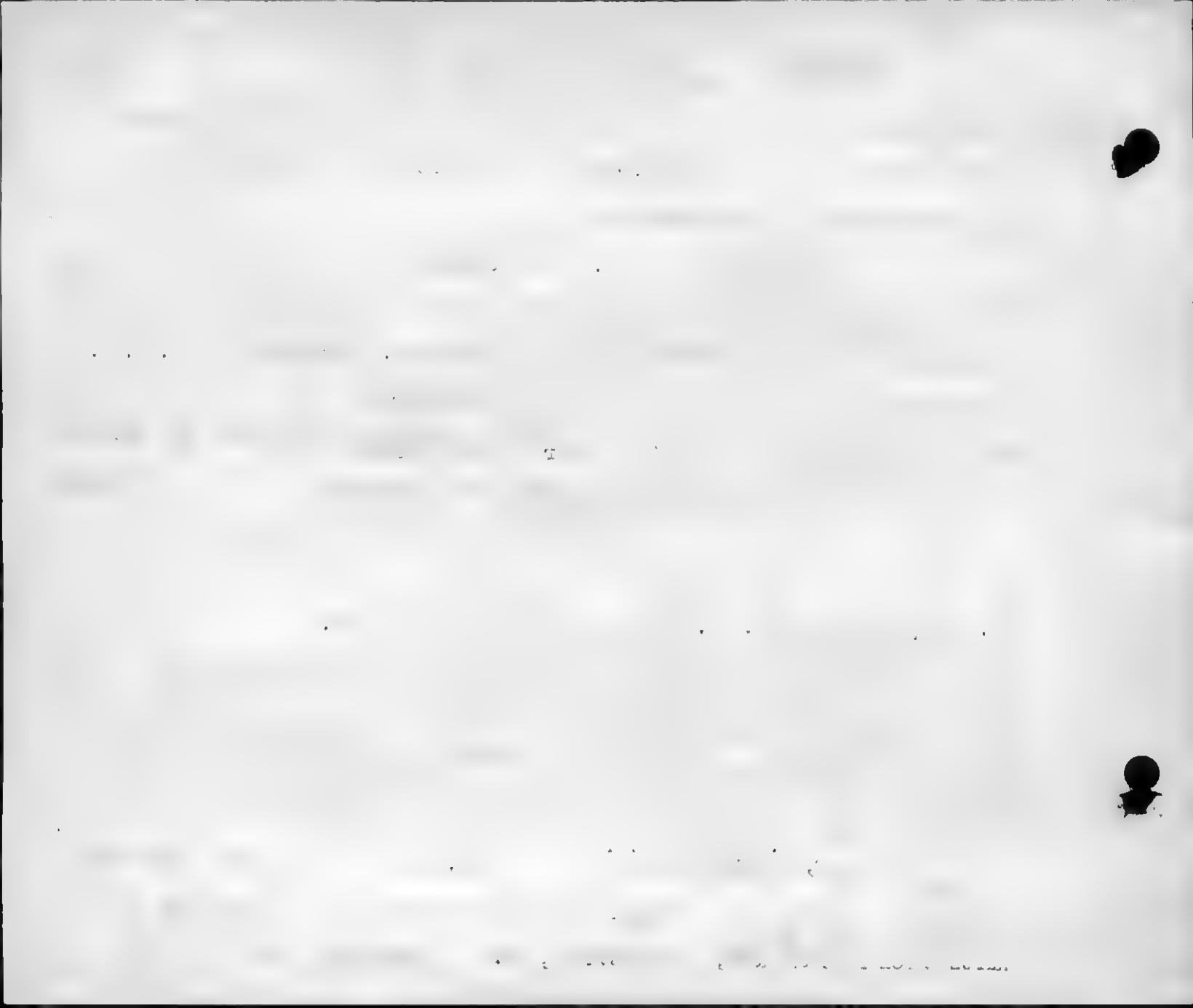
20h. (City or town) (County) (State)

20i. (City or town) (County) (State)

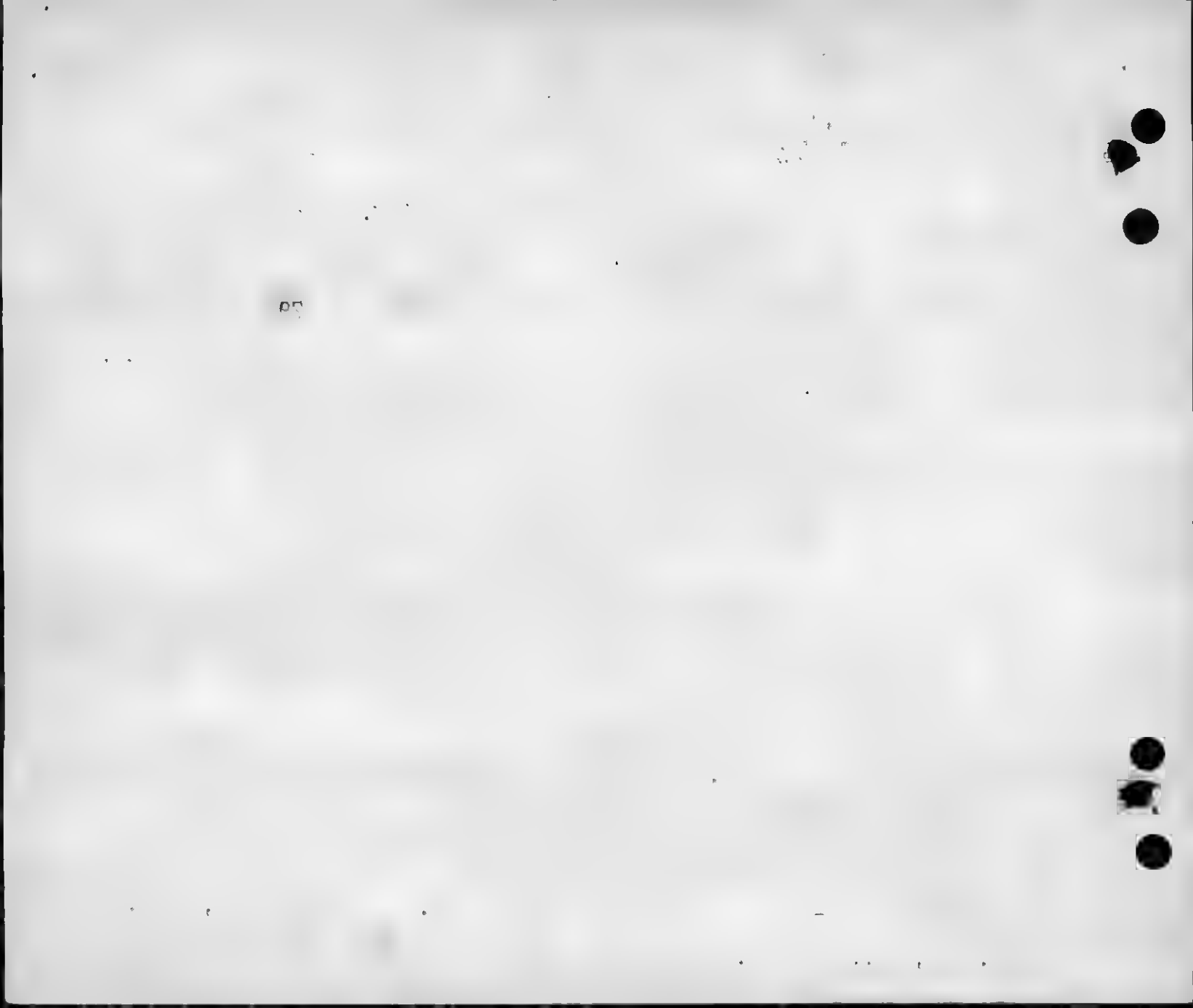
20j. (City or town) (County) (State)

20k. (City or town) (County) (State)

25a. REC'D BY REGISTRAR **JAN 24 '62** 25b. REGISTRAR'S SIGNATURE **John S. Thomas**







00318

item 2 Film 337 2/10/62 L.K.

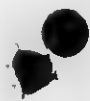
CERTIFICATE OF DEATH

Reg. Dist. No.

00315

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ludwood Sanatorium Towson 4, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle L. Last PERRY		4. DATE OF DEATH Month 1 Day 10 Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Restauranteur		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elisabeth City N.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Thomas C. PERRY		14. MOTHER'S MAIDEN NAME Dora N. Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service:		16. SOCIAL SECURITY NO. 216-05-4643	
17. INFORMANT Mr. Edgar L. Perry Jr.		Address 505 Madison Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OBSTRUCTIVE PULMONARY EMPHYSEMA 5-27-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-4 , 19 61 to 1-10 , 19 62 , that I last saw the deceased alive on 1-10 , 19 62 , and that death occurred at 5:55 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John B. Fress M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/12/62	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		24a. REC'D BY REGISTRAR DATE JAN 11 '62	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be used by the attending physician and completely filled in by the funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

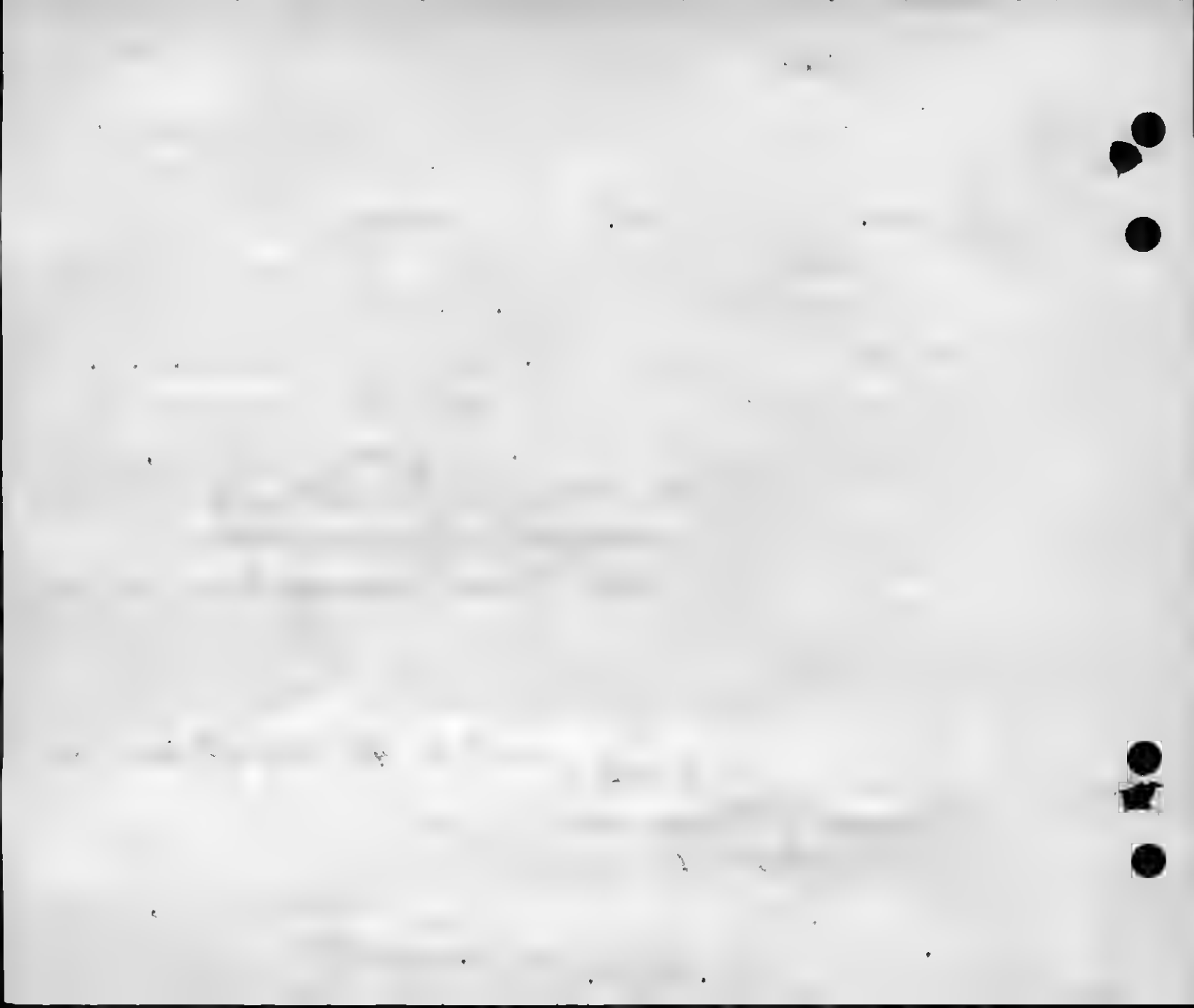
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00319

CERTIFICATE OF DEATH

00316

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u> c. LENGTH OF STAY IN 1b <u>life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box. 62, Glen Arm, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u> d. STREET ADDRESS <u>Box 62</u>	
3. NAME OF DECEASED (Type or print) <u>George Yellott Piper</u> 5. SEX <u>Male</u> 6. CO. OR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Carp.</u> 11. PLACE County & State <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1962</u> 9. AGE In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) <u>69</u> yrs. Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
13. FATHER'S NAME <u>Augustus Piper</u> 14. MOTHER'S MAIDEN NAME <u>Mamie Monroe</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> 16. SOCIAL SECURITY NO. <u>214-12-0446</u> 17. INFORMANT <u>Mrs. Thelma Piper</u> Address <u>Glen Arm, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>Generalized Atherosclerosis</u> (c) <u>Cardio Renal Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>10 yr</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>30</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Oct 8, 1947</u> to <u>January 6, 1962</u> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>1/3, 1962</u> and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u> 22b. DATE SIGNED <u>Jan 9 1962</u> 22d. ADDRESS <u>Balt. 12, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 9, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Waugh Chapel Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore County, Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins & Sons Co</u> ADDRESS <u>4905 York Rd.</u> DATE <u>JAN 9 1962</u> 25a. REC'D BY REGISTRAR <u>JAN 9 1962</u> 25b. REGISTRAR'S SIGNATURE <u>John P. Hearn</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00320

CERTIFICATE OF DEATH

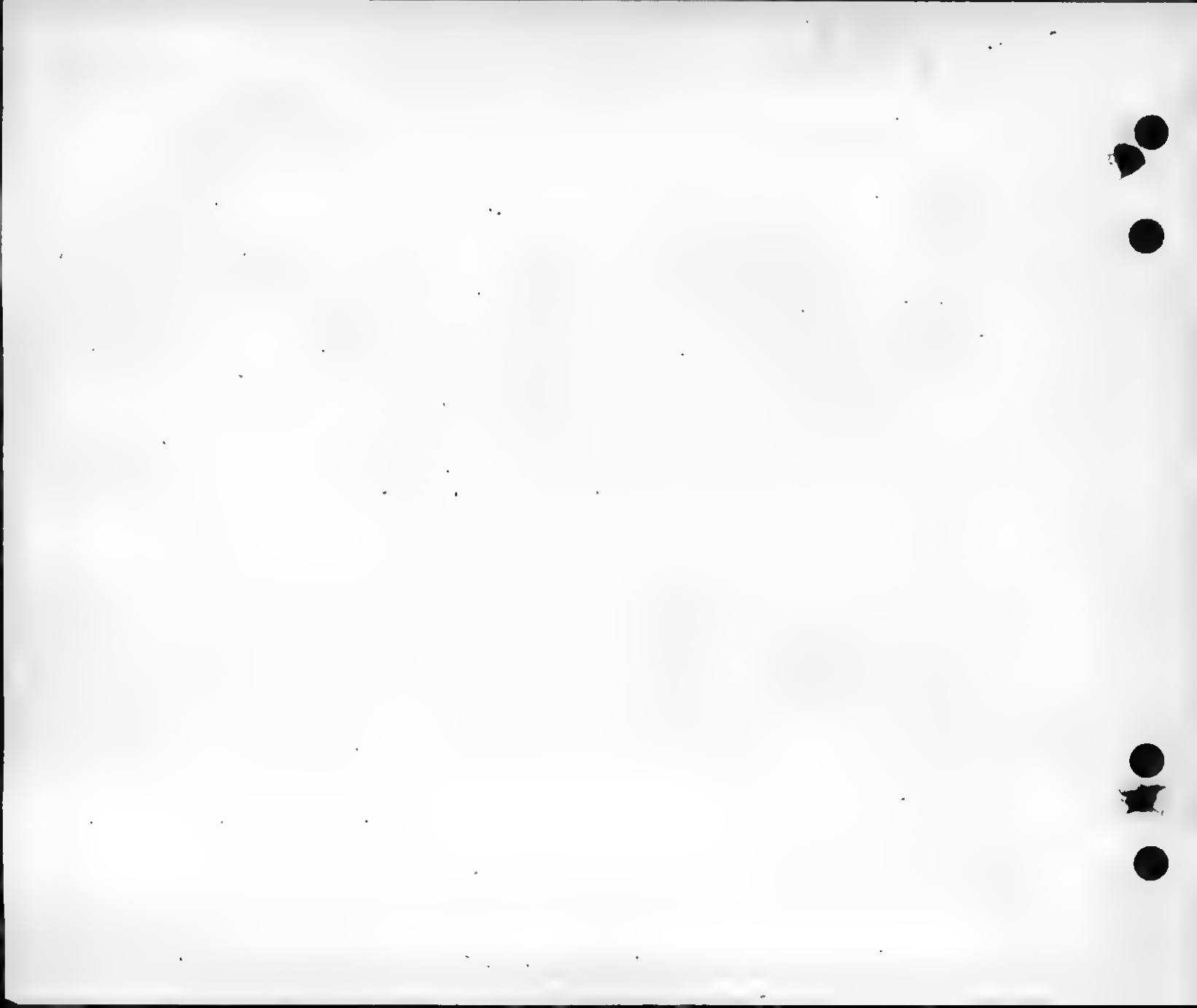
Reg. Dist. No.

00317

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1335 DEANWOOD Rd.</u>		d. STREET ADDRESS <u>1335 DEANWOOD Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Mace</u> Last <u>Plowman</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-23-1896</u>
9. AGE (In years last birthday) <u>65</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>STEPHEN PLOWMAN</u>		14. MOTHER'S MAIDEN NAME <u>ANN SAMSEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>ANN JOHNSON</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic lymphatic Leukemia</u> 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u>	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
19c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		19d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>Jan. 27, 1962</u> that I last saw the deceased alive on <u>Dec. 1961</u> and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R Donald Jandorf</u> M.D.		DATE SIGNED <u>1-27-62</u>	
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>		<u>Balto. 14, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1/31/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR <u>5305 HANFORD Rd.</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. Ruck</u>		DATE <u>JAN 31 '62</u>	

TO HOSE OR A... MAY BE... TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58



Page 4
The law requires that the death certificate be executed within 24 hours after death.
The attending physician, the funeral director, or the medical examiner may be designated as the official certifier. After this certificate has been signed by the official certifier, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
00321
00318
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE South Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville	
d. NAME OF HOSPITAL (If not in hospital, give street address) THE SHEPPARD AND ENOCH PRATT HOSPITAL		d. STREET ADDRESS 778-3	
3. NAME OF DECEASED (Type or print) First Middle Last Eugenia Maxwell Poe		4. DATE OF DEATH Month Day Year January 11 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1880
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis Winslow Poe		14. MOTHER'S MAIDEN NAME Harriet A. Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 331X DUE TO (b) Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia - Paranoid Type 24 hr 2 wk			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) None	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1930 to Jan 11, 1962 that (I) (we) last saw the deceased alive on Jan 10, 1962 and that death occurred at 9:35 PM from the causes and on the date stated above.			
22a. SIGNATURE W. W. Elgin		22b. DATE SIGNED January 11, 1962	
22c. PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		22d. ADDRESS Towson 4, Maryland The Sheppard and Enoch Pratt Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-11-62	
23c. NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		23d. LOCATION (City, town, or county) (State) Greenville, South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Jackson Sons Balto 17 Md.		25a. REC'D BY REGISTRAR DATE JAN 12 '62	
25b. REGISTRAR'S SIGNATURE L. Trans		25c. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00319

00322

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY Baltimore MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Oella	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Powers Av		d. STREET ADDRESS Powers Av	
3. NAME OF DECEASED (Type or print) First SYLVESTER Middle POLLOCK Last POLLOCK		4. DATE OF DEATH Month Jan. Day 1 Year 19 62	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2, 1895
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR: Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Pollock		14. MOTHER'S MAIDEN NAME Annie Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-01-3995	
17. INFORMANT Mrs. Bessie Pollock		Address Oella, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Valvular Disease 7-21-4 DUE TO Valvular Lesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1961 , to Jan. 1, 1962 , that I last saw the deceased alive on Jan. 1, 1962 , and that death occurred at 9:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. McElroy		DATE SIGNED 14 Jan 1962	
PHYSICIAN'S NAME (Type) W. H. McElroy			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-5-62	22c. NAME OF CEMETERY OR CREMATORY Western Star Cem	22d. LOCATION (City, town, or county) (State) Catonsville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. McElroy		24a. REC'D BY REGISTRAR DATE JAN 4 '62	24b. REGISTRAR'S SIGNATURE C. S. Thomas

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

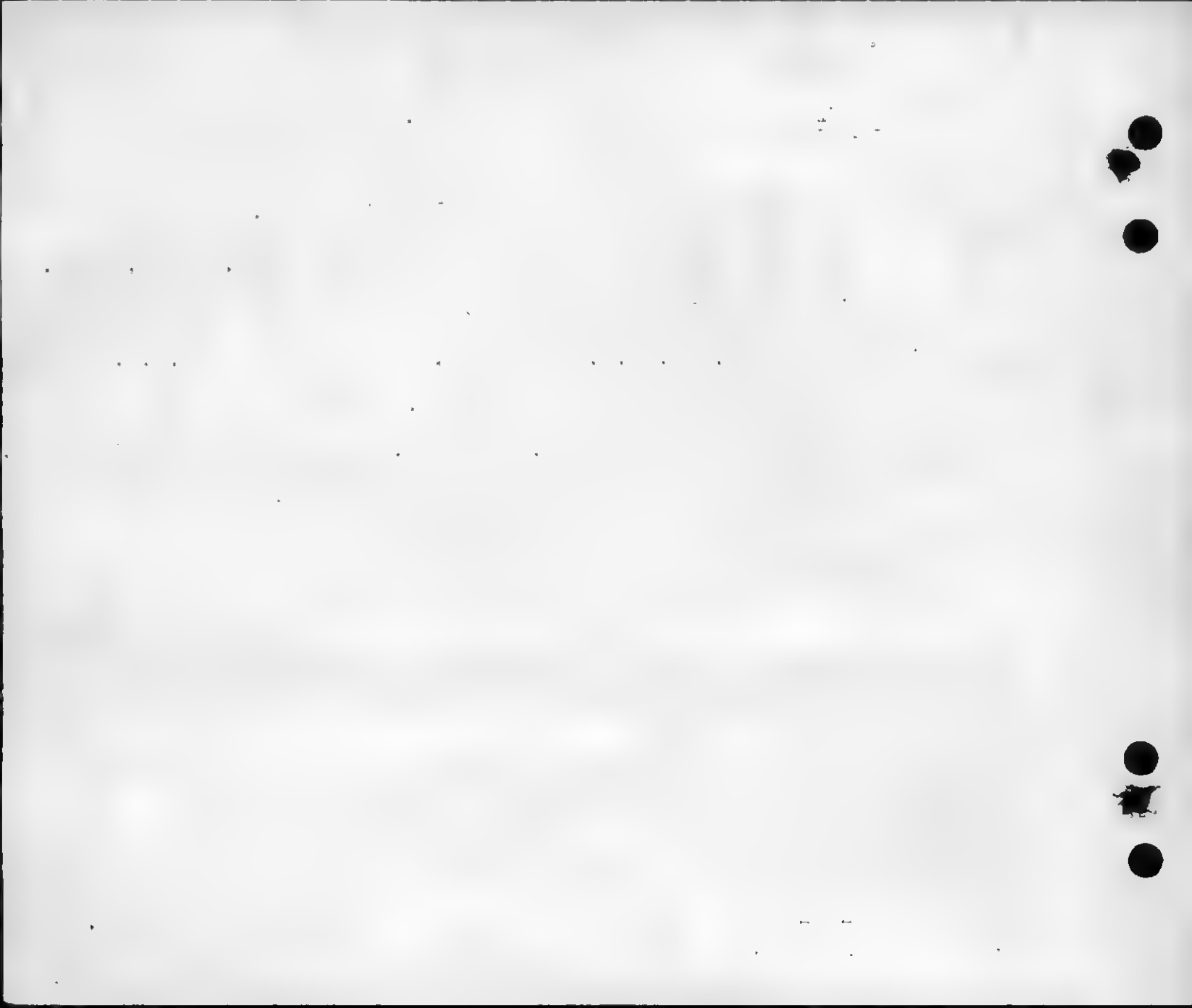
00323

CERTIFICATE OF DEATH

Reg. Dist. No. 10320

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN IB 45 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chapel Hill Convalescent Home		e. STREET ADDRESS 1819 Alto Vista Ave.,	
3. NAME OF DECEASED (Type or print) Edgar Westwood Poole		4. DATE OF DEATH Month Jan. Day 24 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1869
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer B. & O. R.R.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Poole		14. MOTHER'S MAIDEN NAME Mary M. Buxton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Charles I. Naylor		Address 1819 Alto Vista Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Generalized Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 13, 1934 to Jan. 24, 1962 , that I last saw the deceased alive on Jan. 21, 1962 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hg - Balto - Md.	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE SIGNED 1-26-62	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-27-1962	
22c. NAME OF CEMETERY OR CREMATORY Montgomery Chapel		22d. LOCATION (City, town, or county) (State) Claggettville, Md.	
23. GENERAL DIRECTOR'S SIGNATURE G. Howard Strong		24a. REC'D BY REGISTRAR DATE JAN 29 '62	
ADDRESS 3707 North Ave		24b. REGISTRAR'S SIGNATURE Orlando E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the attending physician and completely filled out by the registrar. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled out by the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

00321

1. PLACE OF DEATH o. COUNTY <u>Reisterstown</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Bent Nursing Home</u>		d. STREET ADDRESS <u>2824 Prentiss St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Prater</u>		4. DATE OF DEATH Month Day Year <u>Jan 14 1962</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>e</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-92</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>and</u>	
11. BIRTHPLACE (State or foreign country) <u>and</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sash Prater</u>		14. MOTHER'S MAIDEN NAME <u>Frances Carter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>24-01-8923A</u>	
17. INFORMANT <u>Alice Stone</u>		Address <u>2824 Prentiss St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia (terminal)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Disease with</u> DUE TO <u>cardiac decompensation</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 8, 1962</u> , to <u>January 14, 1962</u> , that I last saw the deceased alive on <u>January 14th, 1962</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		M.D. <u>48 Main Street</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel</u>		M.D. <u>Reisterstown Baltimore Co. Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-18-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Edmunds cm</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joe S. Nelson</u>		24a. REC'D BY REGISTRAR DATE <u>Jan 17 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>John L. Hanes</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician or by the funeral director. This certificate has been signed by the attending physician and completely filled out by the funeral director. TO FUNERAL DIRECTOR: This certificate should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

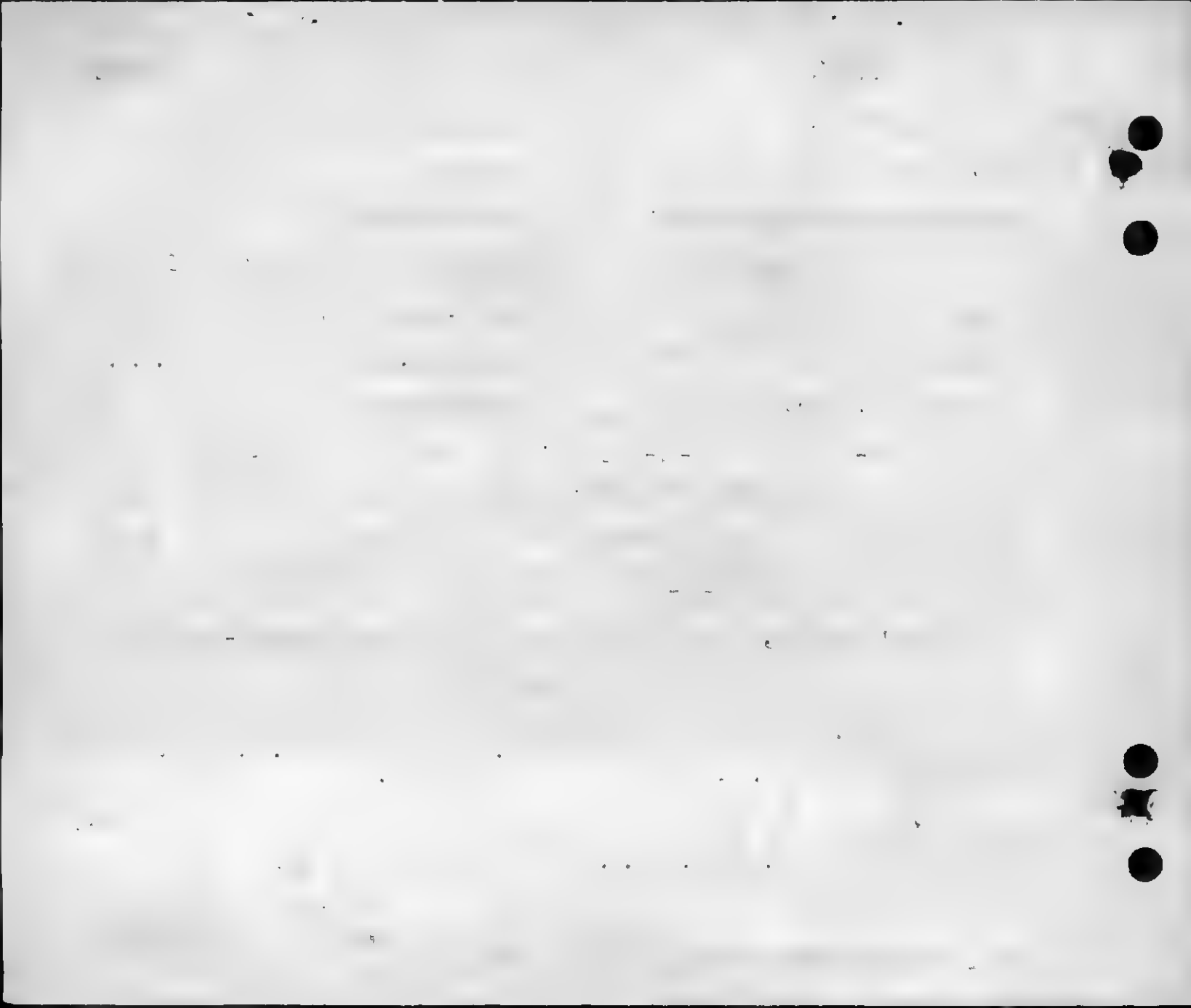
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00325

00322

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) Fort Howard		c. CITY OR TOWN (if outside corporate limits, write RJRAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN b 51 Days		d. STREET ADDRESS 1416 Chesapeake Court	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle C Last PRICE		4. DATE OF DEATH Month January Day 3 Year 1962	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 2, 1891	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (Country & State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Archibald C. Price		14. MOTHER'S MAIDEN NAME Annie Salawhite	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO 217-07-0823	
17. INFORMANT WW-1		Address Clin Rec VAH Baltimore Md - Ft Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. BRONCHOPNEUMONIA DUE TO FRACTURE OF RIGHT HIP on 9-25-61		INTERVAL BETWEEN ONSET AND DEATH 12 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease; severe; Anemia; Post-Operative Adenocarcinoma-Rectum		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Slipped and fell (at home)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Sept. 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Maryland	
21. I certify that (this hospital) attended the deceased from Nov. 13, 1961 to Jan. 3, 1962 , that (we) last saw the deceased alive on Jan. 3, 1962 , and that death occurred at 2:25 p.m. from the causes and on the date stated above.			
22a. SIGNATURE A. A. Bulls		22b. DATE SIGNED 1-3-62	
22c. PHYSICIAN'S NAME (Type) Antonio A. Bulls, M.D.		22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division	
22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-8-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O Wilson Funeral Home		25a. REC'D BY REGISTRAR JAN 5 1962	
25b. REGISTRAR'S SIGNATURE Arthur S. Thayer		DATE	



TO HO...
death...
to FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

after within 24 hours after death.

00326

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN b 14 Days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. STREET ADDRESS 402 Jack Street	
3. NAME OF DECEASED (Type or print) JOHN W. PUTSCHKY		4. DATE OF DEATH Month January Day 25 Year 1962	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH October 23, 1917		9. AGE (in years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State or foreign country) Brooklyn, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Putschky		14. MOTHER'S MAIDEN NAME Minnie Gast	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO 217-09-5511	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LAENNEC'S CIRRHOSIS DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). BRONCHOPNEUMONIA Operation 1/24/62: Tracheotomy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1962 to Jan. 25, 1962 that (I) (we) last saw the deceased alive on Jan. 25, 1962 , and that death occurred at 12:05 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Irving Freeman, M.D.		22b. DATE SIGNED 1/25/62	
22c. PHYSICIAN'S NAME (Type or print) IRVING FREEMAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18 MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-27-62	
23c. NAME OF CEMETERY OR CREMATORY Adair Hill Cem		23d. LOCATION (City, town or county) (State) Brooklyn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. C. Kelly		25a. REC'D BY REGISTRAR JAN 30 '62	
ADDRESS Home 130 E. Lake		25b. REGISTRAR'S SIGNATURE C. S. P. Hays	



TO HO...AL...NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The attending physician or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

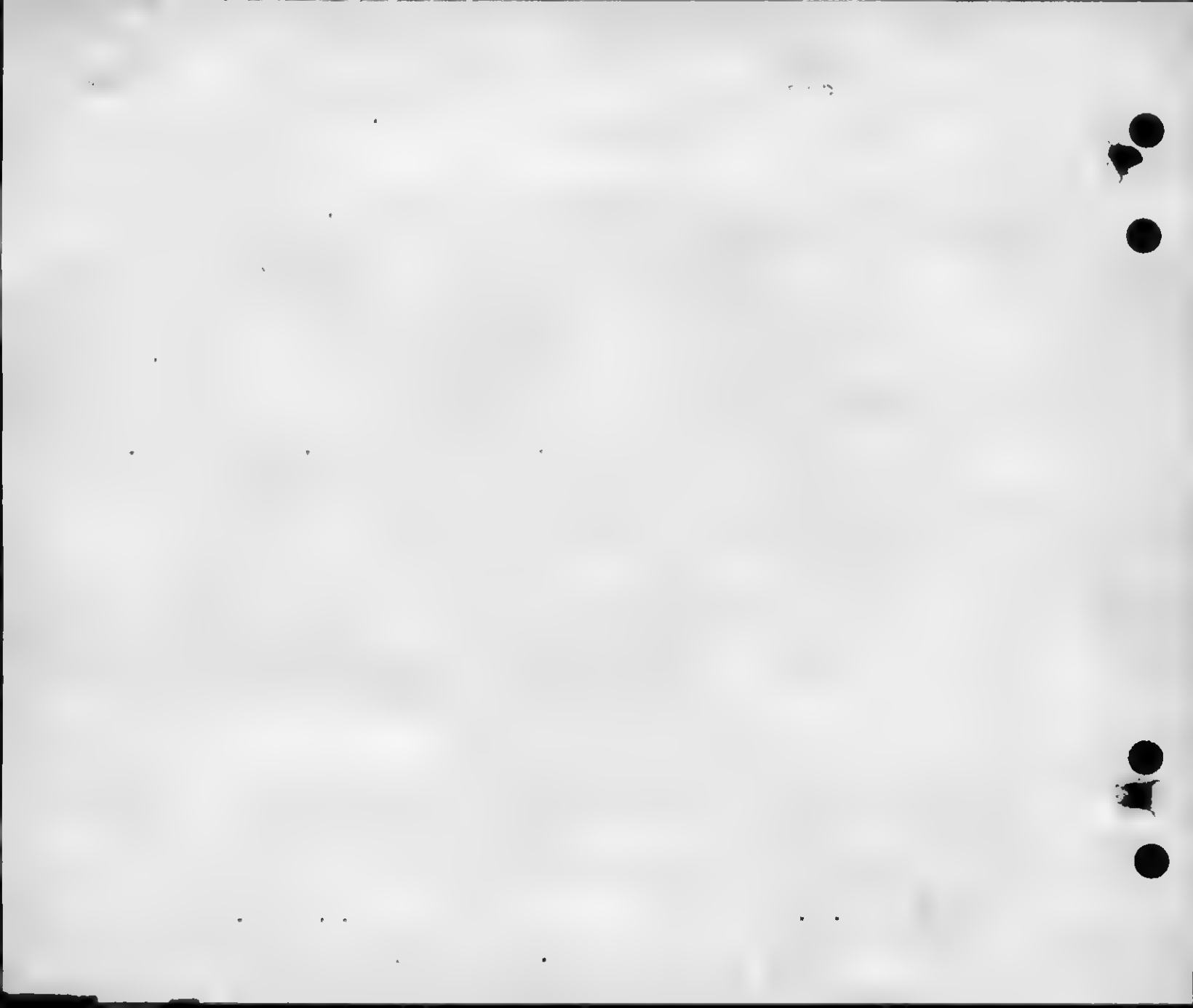
CERTIFICATE OF DEATH

00327

00324

1. PLACE OF DEATH a. COUNTY Balto MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Paradise Nursing Home 18 Paradise Ave		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto d. STREET ADDRESS 1514 Sycamore St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Jane Rabadoux First Middle Last 5. SEX F 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH July 1, 1868 9. AGE (In years last birthday) 93 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTH-PLACE (County & State, or foreign country) England 12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT Wm. T Upton Lyndale Rd. Lake Shore Md. 18. CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 43X DUE TO Hypertension Cardio Vascular Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Chronic Urinary tract infection Decubitus Ulcers Multiple 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) 20f. (City or town) 1/3/62 20g. (County) 1/27/62 21. I certify that (I) (this hospital) attended the deceased from 1/3/62 to 1/27/62, that (I) (we) last saw the deceased alive on 1/27/62, and that death occurred at 4:00 PM, from the causes and on the date stated above. 22a. SIGNATURE W. E. McGrothland 22b. DATE SIGNED 1/29/62 22c. PHYSICIAN'S NAME (Type) W. E. McGrothland 22d. ADDRESS 1303 Franklin Rd 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1.30. 62 23c. NAME OF CEMETERY OR CREMATORY Glen Haven 23d. LOCATION (City, town or county) A.A. CO Md. 24. FUNERAL DIRECTOR'S SIGNATURE McGully 130 E Fort Ave Balto 30 Md. 25a. REC'D BY REGISTRAR JAN 30 '62 25b. REGISTRAR'S SIGNATURE W. J. E. P. P.	

VR A15 (4)
ISM 9/60



TO HOWARD COUNTY: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

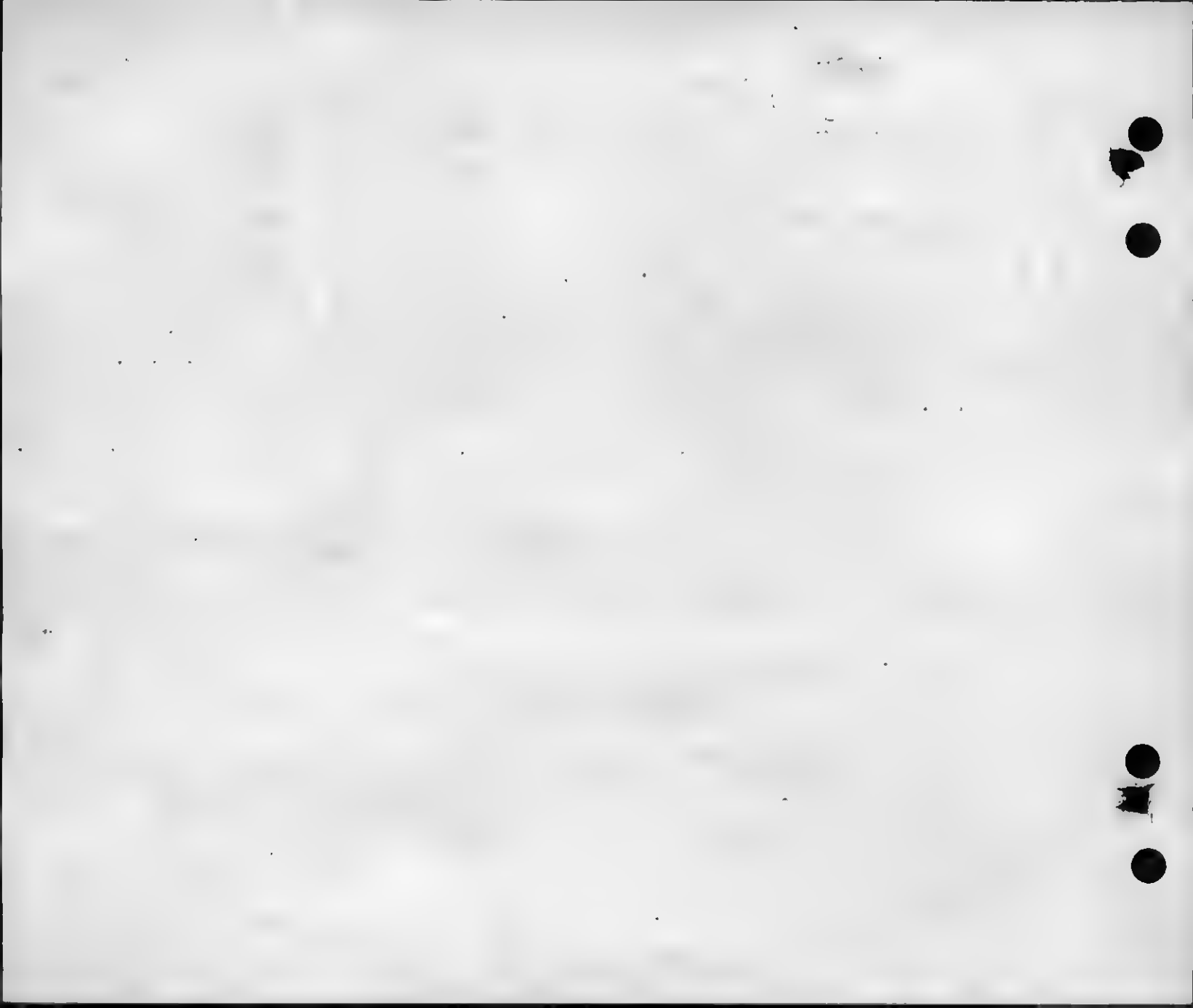
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00328

00325

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Caton Ridge Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 208 South Eutaw Street	
3. NAME OF DECEASED (Type or print) Howard Ramsey		4. DATE OF DEATH Month Day Year January 26, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Sept. 27, 1896	9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Packing Shipping Department		10b. KIND OF BUSINESS OR INDUSTRY Macon, Georgia	11. BIRTH-PLACE (County & State, or foreign country) U. S. A.
13. FATHER'S NAME J. W. Ramsey		14. MOTHER'S MAIDEN NAME Annie Dewberry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 260-03-2267	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Active sclerotic Cardio Vasc Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/19/62 to 1/26/62, that (I) (we) last saw the deceased alive on 1/26/62, and that death occurred at 6:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Cliff Ratliff, Jr.		22b. DATE SIGNED 1/27/62	
22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.		22d. ADDRESS 4605 EDMONDSON AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-31-62	
23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Tucker & Sons		25a. REC'D BY REGISTRAR FEB 1 1962	
ADDRESS Baltimore 17, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	



CERTIFICATE OF DEATH

Reg. Dist. No. 00326

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 E. LINDWOOD AVE		d. STREET ADDRESS 1 3000 E. LINDWOOD AVE	
3. NAME OF DECEASED (Type or print) First ANNA Middle M Last RASSA		4. DATE OF DEATH Month JAN Day 29 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 4 1885
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Bloberger		14. MOTHER'S MAIDEN NAME Meta Prestpopp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT HUGUST RASSA		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) 3 hrs. 2 yrs.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1 - 1952 to Jan 27 1962 , that I last saw the deceased alive on Jan 21 1962 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George Sawyer M.D.		ADDRESS (Street, city or town, state) 4808 Harford Rd - Balto. Md.	
PHYSICIAN'S NAME (Type) GEORGE SAWYER, M.D.		DATE SIGNED 1/31/62	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Feb 2 1962	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE CHAS F. EVANS & Son		ADDRESS 8802 Harford Rd	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE 1/31/62	





MD STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

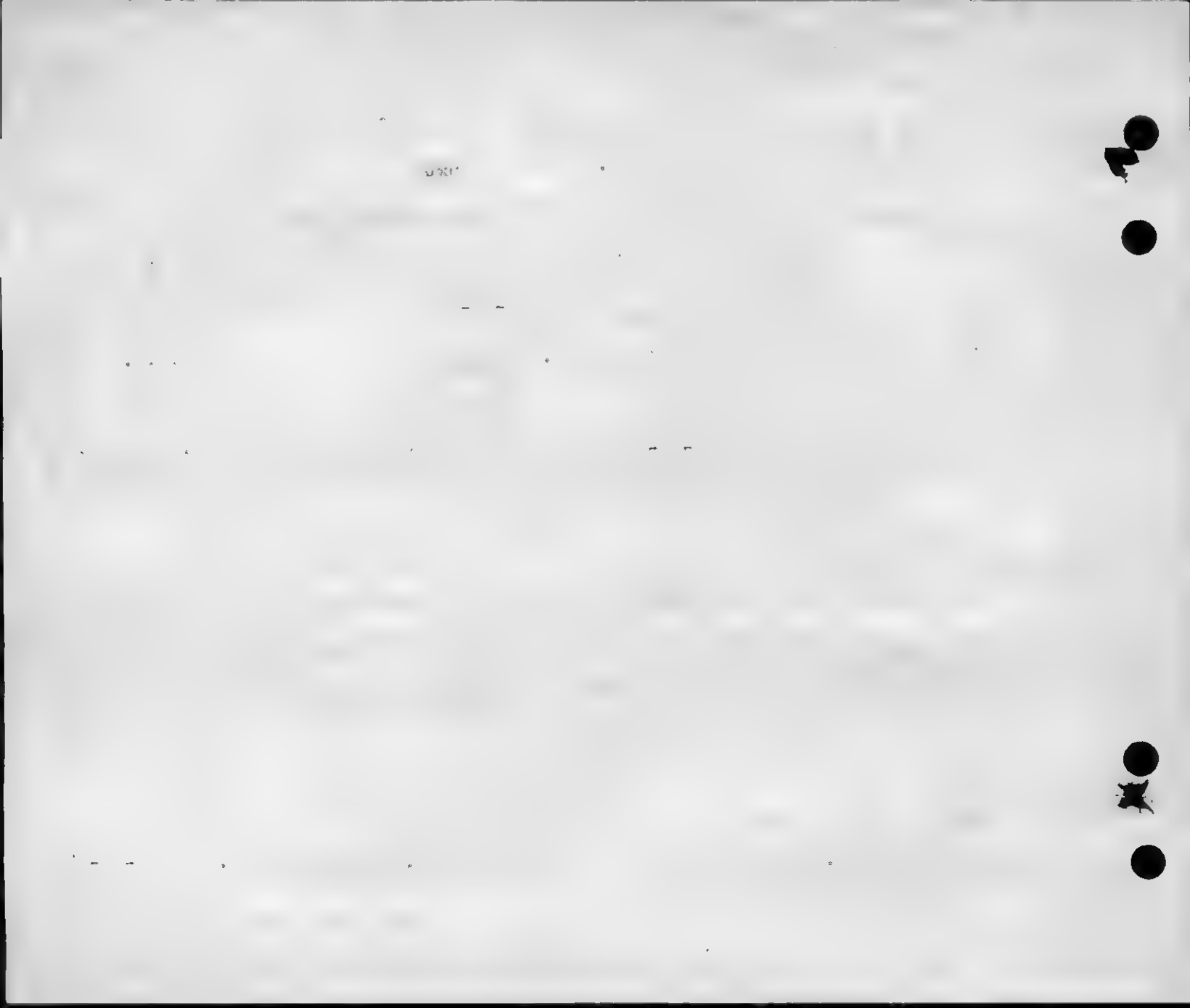
00331 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00328

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN lb 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton 4	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 319 Broadway Rd.		d. STREET ADDRESS 1406 Maywood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Fallon Ray		4. DATE OF DEATH Last, Jan. 27 19 62		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-25-15	
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Ray		14. MOTHER'S MAIDEN NAME Doris Fallon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWII		16. SOCIAL SECURITY NO. 217-05-8251		17. INFORMANT Mrs. Mary C. Ray, 1406 Maywood Ave., Ruxton 4, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion (b) 420.1 (c) none		(b) none (c) none		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Bronchial Asthma					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none		20g. (County) none		20h. (State) none	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/>. Accident <input type="checkbox"/>. Suicide <input type="checkbox"/>. Homicide <input type="checkbox"/>. Undetermined manner <input type="checkbox"/>					
ACTUAL EXAMINER'S NAME (Type) D. D. Caples, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-29-62	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1-30-62		22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial	
22d. LOCATION (City, town, or country) Cockeysville, Md.		22e. (State) Md.		22f. (County) Harford	
23. FUNERAL DIRECTOR Brooks Funeral Service, Inc., Towson 4, Md.		24a. REC'D BY REGISTRAR JAN 31 '62		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Hines</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay occurs, it should be executed within 72 hours after death. Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00332

00329

1. PLACE OF DEATH

a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CATONSVILLE

c. LENGTH OF STAY (If not in hospital, give street address)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

5902 CHARNWOOD RD.

2. USUAL RESIDENCE (Where deceased lived, if institutional residence before admission)

a. STATE

MD.

b. COUNTY

BAKTO

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X CATONSVILLE

d. STREET ADDRESS

5902 CHARNWOOD RD.

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

ROSALIE

REDDEN

4. DATE OF DEATH

JAN

9

1962

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

JAN. 14, 1870

9. AGE (In years last birthday)

91 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEKEEPER

10b. KIND OF BUSINESS OR INDUSTRY

HOME

11. BIRTHPLACE (County & State, or foreign country)

MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

BEACH BOARD

14. MOTHER'S MAIDEN NAME

NOT KNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

W Keith Redden - 5902 Charnwood Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

492X DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

5 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Arteriosclerosis Generalized

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Hour a.m. p.m.

19

While at work ☐ Not While at work ☐

21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1962 to Jan. 9, 1962 that (I) (we) last saw the deceased alive on Jan. 8, 1962, and that death occurred at 11:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE

Walter McKay

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22b. DATE SIGNED

Jan 13, 1962

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

burial 1-12-62

23c. NAME OF CEMETERY OR CREMATORY

Woodlawn Cem.

23d. LOCATION (City, town or county)

Woodlawn

(State)

MD.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Dorothy Carverney L.H.

Catonville, Md.

25a. REC'D BY REGISTRAR

DATE JAN 15 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Hume

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL death. Page 4 TO FUNERAL director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

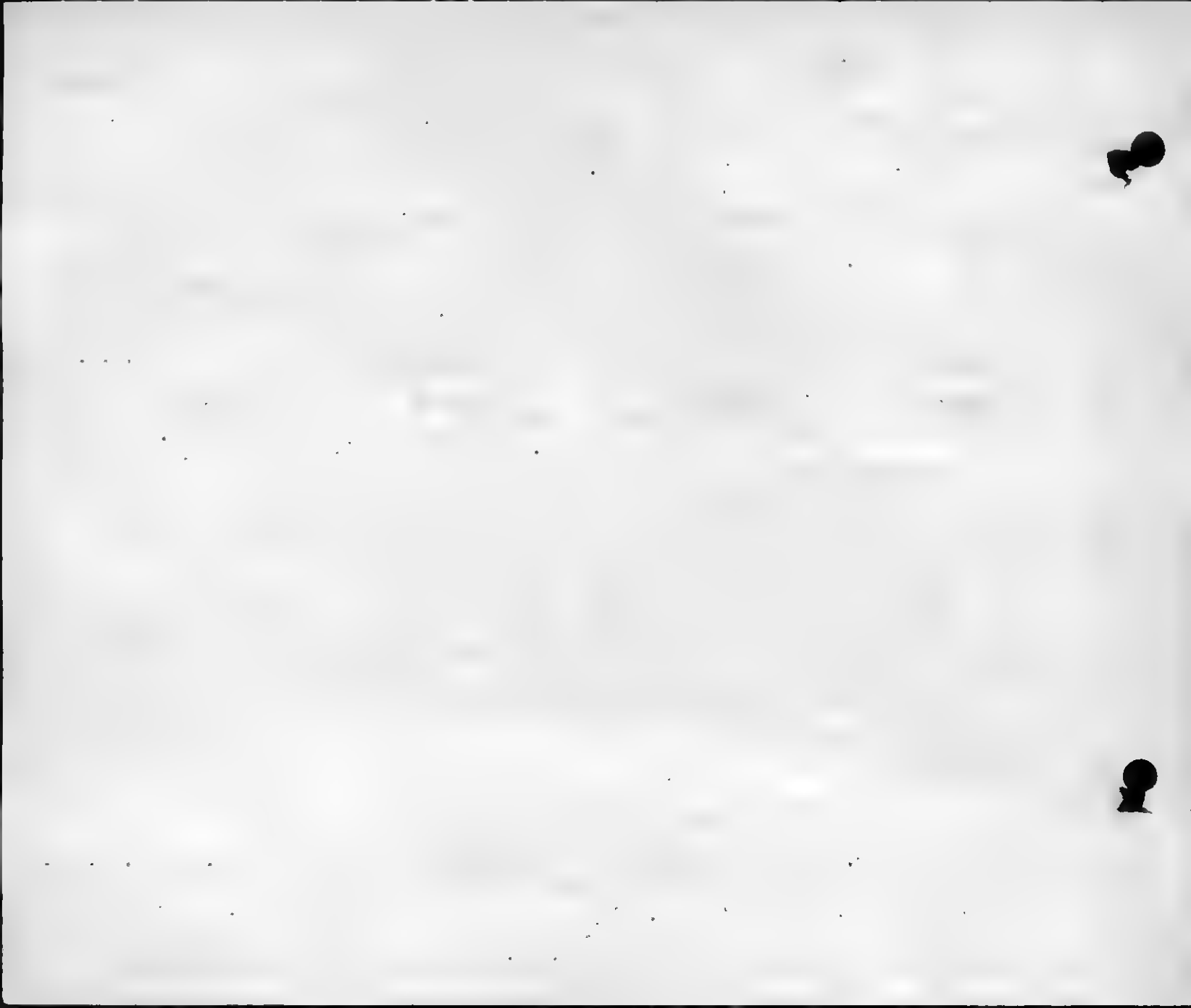
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00333

00330

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Holbrook c. LENGTH OF STAY IN lb 4 Mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chapel Hill Convalescent Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 7 d. STREET ADDRESS 2533 Cedar Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Lydia Reichlin First Middle Last		4. DATE OF DEATH January 13 1962 Month Day Year	
5. SEX Female 6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 6, 1872 9. AGE (In years last birthday) 89 yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 11. BIRTHPLACE (County & State, or foreign country) Switzerland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Heinrich Rebsamen		14. MOTHER'S MAIDEN NAME Marie Gonzenbach	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Werner Kloetzli, Baltimore 7, Maryland Address 2533 Cedar Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (b) Arterio Sclerotic Cerebro Vascular Disease (c) 7 yrs DUE TO		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombophlebitis of the right leg 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 26, 1959 to Jan 13, 1962 ; that (I) (we) last saw the deceased alive on Jan 12, 1962 , and that death occurred at 5 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Albert Schochat M.D.		22b. ADDRESS 4111 Liberty Heights Ave., Balto. 7, Md.	
22c. PHYSICIAN'S NAME (Type) Dr. Albert Schochat		22d. ADDRESS 4111 Liberty Heights Ave., Balto. 7, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-62	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town or county) (State) Randallstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Byers		25a. REC'D BY REGISTRAR JAN 17 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Hume	



FOR STATE HEALTH DEPT.

TO DEPUTY M. J. DAVIS: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

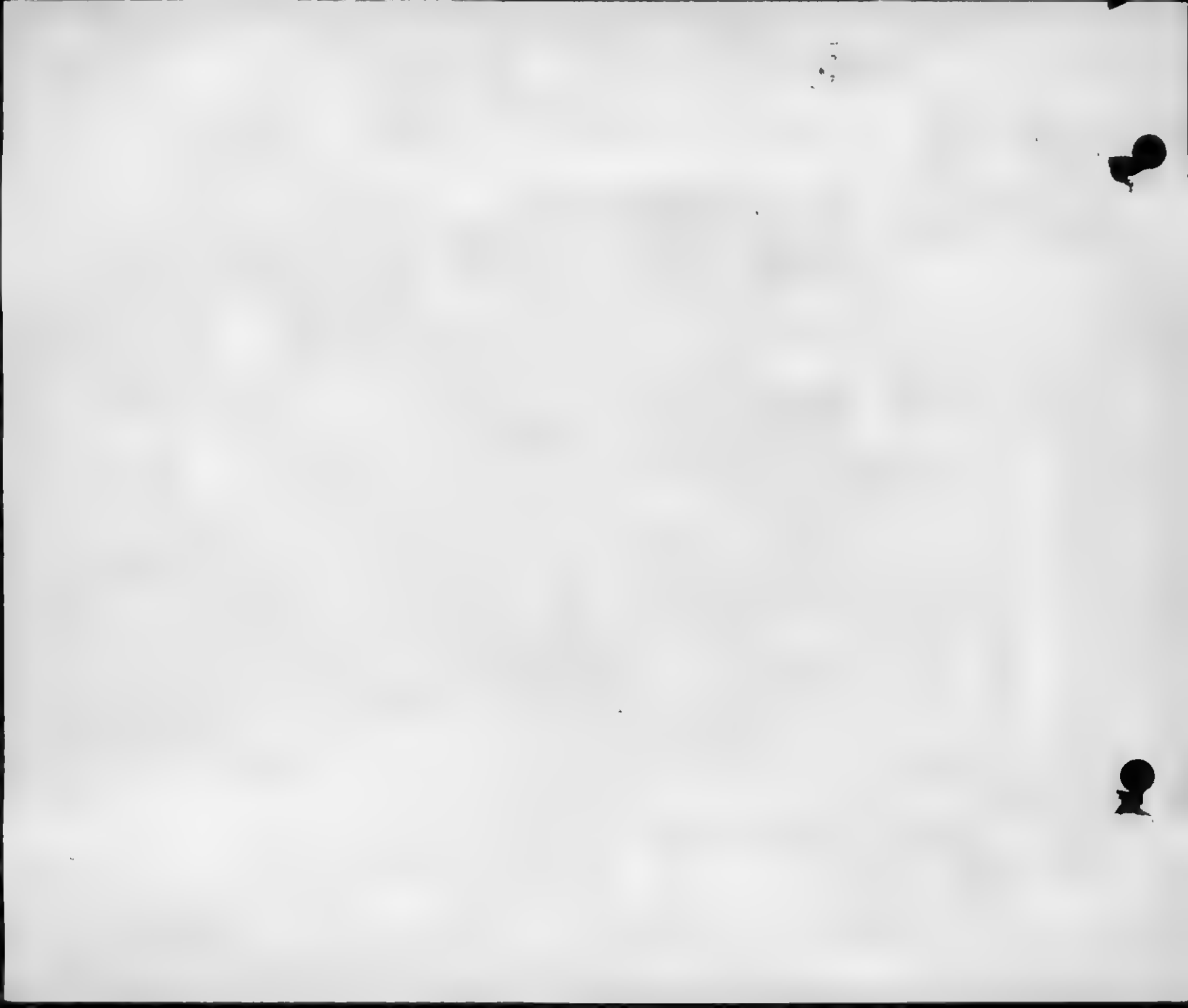
00334. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 5, 6, & 7 Film Group 1/2/62

00331

1. PLACE OF DEATH
a. COUNTY Balto. MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto.
c. LENGTH OF STAY IN Balto.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holly Neck Rd. Balto. 21
2. USUAL RESIDENCE (Where deceased lived, if Institution. Residence before admission)
a. STATE Md. b. COUNTY Balto.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto. 21 Md.
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) Philip John Remlein
First Middle Last
4. DATE OF DEATH Jan. 24 1962
Month Day Year
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH Oct. 1894
9. AGE In years IF UNDER 1 YEAR IF UNDER 24 HRS. (less birthday) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nanny Man
10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.
11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Remlein
14. MOTHER'S MAIDEN NAME Frederika Youngkon
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Sister (810 Parkes Terrace)
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) A-S-C-V-Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) None
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None
20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE M.B. Davis CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) M.B. DAVIS MD M.D. ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER D. J. Davis MD DATE SIGNED 1/25/62
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1-25-62 22c. NAME OF CEMETERY OR CREMATORY Sacred Heart 22d. LOCATION (City, town, or country) (State) Balto. Md.
23. FUNERAL DIRECTOR John G. Connelly ADDRESS 418 Eastern Blvd 24a. REC'D BY REGISTRAR Arthur L. Hines 24b. REGISTRAR'S SIGNATURE Arthur L. Hines
DATE JAN 26 '62



FOR STATE
HEALTH DEPT.

00335

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00332

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>East</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Norwood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6919 DELVALE PLACE</u>		1. STREET ADDRESS <u>6919 DELVALE PLACE</u>	
3. NAME OF DECEASED (Type or print) <u>EDITH</u>		4. DATE OF DEATH <u>JANUARY 23 1962</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 23, 1903</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11c. BIRTHPLACE (State or foreign country) <u>Providence, Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u> </u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MRS IRMA MALONE</u>		Address <u>6019 Delvalle Place</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>H-S-C-V-DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis MD</u>		DATE SIGNED <u>1/25/62</u>	
EXAMINER'S NAME (Type) <u>M. B. Davis MD</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-27-1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	22d. LOCATION (City, town, or county) <u>BALTIMORE County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LILLY & ZILOR INC</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	
ADDRESS <u>1901 EASTON AVENUE</u>		DATE <u>JAN 26 '62</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be signed by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

Reg. Dist No.

00333

00336

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLGATE</u>				c. LENGTH OF STAY IN lb			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>508 OLD NORTH POINT RD</u>				d. STREET ADDRESS <u>508 OLD NORTH POINT ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>RIPPEL</u>				4. DATE OF DEATH Month Day Year <u>JAN</u> <u>5</u> <u>1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 7, 1895</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FILTERER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>YEAST</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>RIPPEL</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>152-18-6719215-09-68</u>			
17. INFORMANT <u>MRS ANNA SMITH</u>				Address <u>6524 ST. HELENA AV</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN TUMOR</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/1/61</u> , 19 <u>61</u> , to <u>1/5/62</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1/5/62</u> , 19 <u>62</u> , and that death occurred at <u>5:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Max Baum</u>				ADDRESS (Street city or town, State) <u>7422 Eastern Ave</u>			
PHYSICIAN'S NAME (Type) <u>MAX BAUM</u>				DATE SIGNED <u>1/6/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/9/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAR LAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM FUNERAL HOME - DUNDALK MD.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 10 '62</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. T. T. T.</u>	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute in duplicate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00334

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>208 Main Street</u>		e. STREET ADDRESS <u>1116 Reisterstown Road</u>	
3. NAME OF DECEASED (Type or print) <u>George Edward Roberts Jr.</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>13,</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1929</u>
9. AGE (In years last birthday) <u>32 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George E. Roberts Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Glady's Wade</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>138-22-9260</u>	
17. INFORMANT <u>Mrs. Helen L. Roberts</u>		Address <u>Owings Mills Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fractured Skull (auto accident)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>None</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>struck utility pole & his car</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:35 am Jan 13 1962</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	20f. (City or town) (County) (State) <u>Reisterstown, Balto. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 16, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Linden, I.J.</u>	
23. FUNERAL DIRECTOR <u>J. T. Mline Sons</u>		24a. REC'D BY REGISTRAR <u>JAN 16 '62</u>	
ADDRESS <u>Reisterstown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 2 is retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00338

00335

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHADY NOOK CONVALESCENT HOME</u>			d. STREET ADDRESS <u>5546 GWYNN OAK AVE</u>		
3. NAME OF DECEASED (Type or print) <u>CAROLINE VIRGINIA ROBERTSON</u>			4. DATE OF DEATH <u>JAN. 20, 1962</u>		
5. SEX <u>F.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT. 16, 1879</u>			9. AGE (In years, last birthday) <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13. FATHER'S NAME <u>PHINNUS GETZENDANNER</u>			14. MOTHER'S MAIDEN NAME <u>SARAH WEEKS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		
17. INFORMANT <u>MRS. HELEN GETZENDANNER</u>			Address <u>5546 GWYNN OAK AVE, BALTO. 7, MD.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular C.V. disease</u> 7-22-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Pneumonia</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work Not While at work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. City or town (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June, 1961</u> to <u>Jan. 20, 1962</u> . That (I) (we) last saw the deceased alive on <u>Jan. 20, 1962</u> and that death occurred <u>at home</u> from the causes and on the date stated above					
22a. SIGNATURE <u>D. C. MacLaughlin</u>			22b. DATE SIGNED <u>JAN 23 '62</u>		
22c. PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin, M.D.</u>			22d. ADDRESS <u>4508 Edmondson Village</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>1/23/62</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>			23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE</u>			25a. REC'D BY REGISTRAR <u>JAN 23 '62</u>		
ADDRESS <u>4101 EDMONDSON AVE.</u>			25b. REGISTRAR'S SIGNATURE <u>W. A. S. Pinner</u>		



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

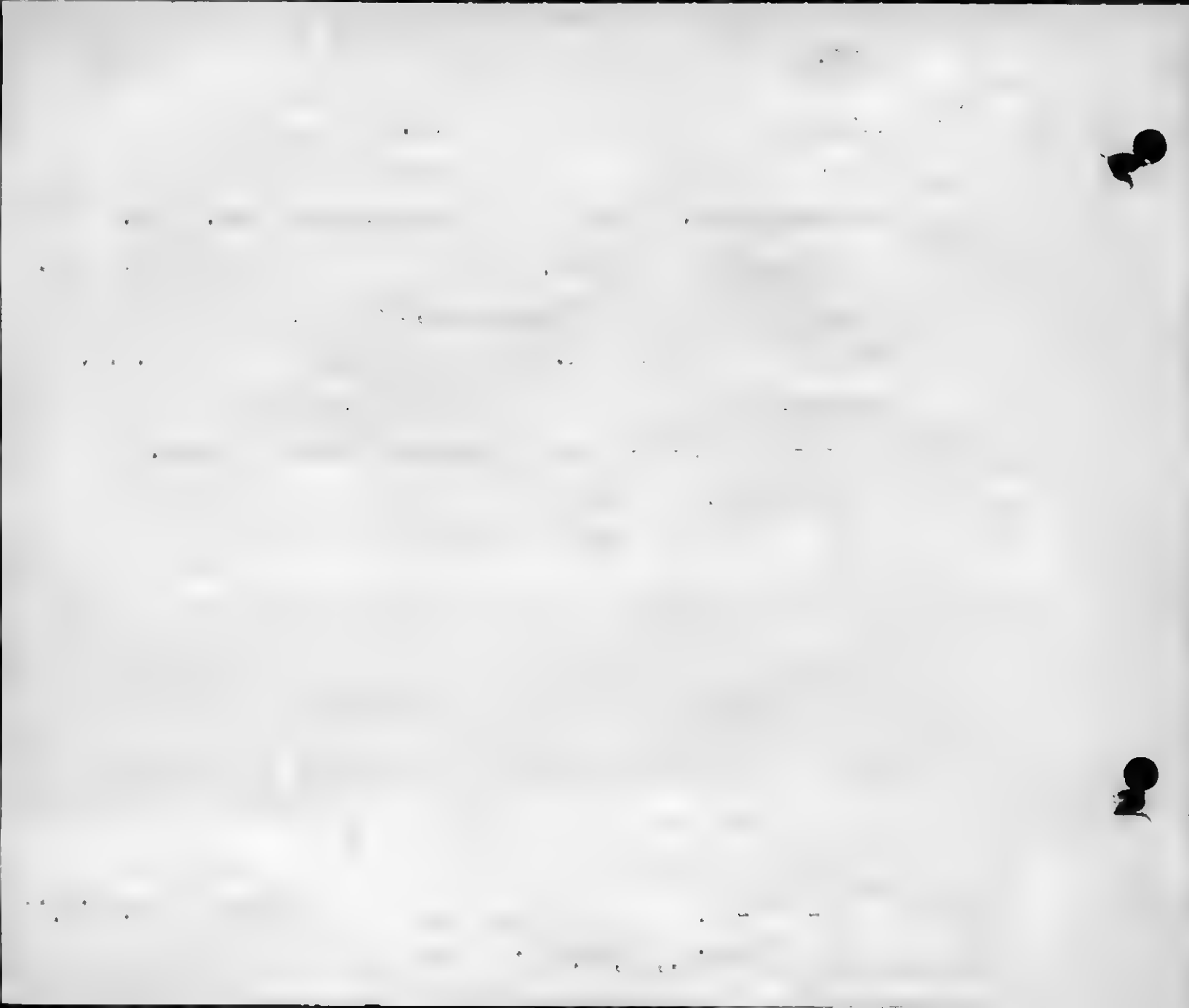
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00339

00336

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not last on; Residence before admission) a. STATE Ma. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1804 Maxwell Ave. # 22		d. STREET ADDRESS 1804 Maxwell Ave. # 22	
3. NAME OF DECEASED (Type or print) FRANCES RODENBERG.		4. DATE OF DEATH January 15, 19 62.	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH August 2, 1884		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months 7 Days 15 IF UNDER 24 HRS.: Hours 15 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY House Work. 11. BIRTHPLACE (County & State, or foreign country) Germany	
13. FATHER'S NAME Ferdinand Dahms		14. MOTHER'S MAIDEN NAME Alvina ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-34-4354 17. INFORMANT Elizabeth Fritz Address Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.] 20c. TIME OF INJURY Month, Day, Year 1-12-62 20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 234 S. Conkling St. 20f. (City or town) Ba. Co., Md. (County) Ba. Co., Md. (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-3-62 19 62 , to 1-15-62 , 19 62 , that (I) (we) last saw the deceased alive on 1-12-62 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John Constantini M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 1-16-62	
22c. PHYSICIAN'S NAME (Type) JOHN CONSTANTINI		22d. ADDRESS 234 S. Conkling St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-18-62.	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) 7225 Eastern Blvd. Ba. Co., Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeiler ADDRESS 901 S. Conkling St. Balto., Md.		25a. REC'D BY REGISTRAR JAN 22 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00340

Item 2 Film 9305 1/10/62 iwk

00337

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. STREET ADDRESS 1030 Homewood Avenue	
3. NAME OF DECEASED (Type or print) First Roda Middle Blanch Last Rogers		4. DATE OF DEATH Month 1 Day 4 Year 1962	
5 SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/181
9 AGE (In years lost birthday) yrs 80		10. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11 BIRTHPLACE (State or foreign country) W. Va		12 CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Silas Dary		14. MOTHER'S MAIDEN NAME Dona Everett	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17 INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 10.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Arteriosclerotic Heart Disease DUE TO 10 yrs. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Far Advanced Pulmonary Tuberculosis			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21 I certify that (I) (this hospital) attended the deceased from 7/31/1961 to 1/4/1962 that (I) (we) last saw the deceased alive on 1/4/1962 and that death occurred at P.M. from the causes and on the date stated above.	
22a. SIGNATURE W. Newcomer		22b. DATE SIGNED 1/4/62	
22c. PHYSICIAN'S NAME (Type) W. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 5/1/62	23c. NAME OF CEMETERY OR CREMATORY Worfield	23d. LOCATION (City, town, or county) (State) Elkton, Md.
24. FUNERAL DIRECTOR'S SIGNATURE James L. G. Fisher, Superintendent		25a. REC'D BY REGISTRAR DATE JAN 8 '62	
25b. REGISTRAR'S SIGNATURE Robert S. Thomas			

By Phone : 3/1/62

Res. should actually be Montg. Co.
since they have the tbc. case.

B. City refused to accept the death
as a City resident.

The City address was from a
guest to the Asbury Home.

A copy will be sent to Montg. Co.

ITS.

3/1/62

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 1-55 10M--

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

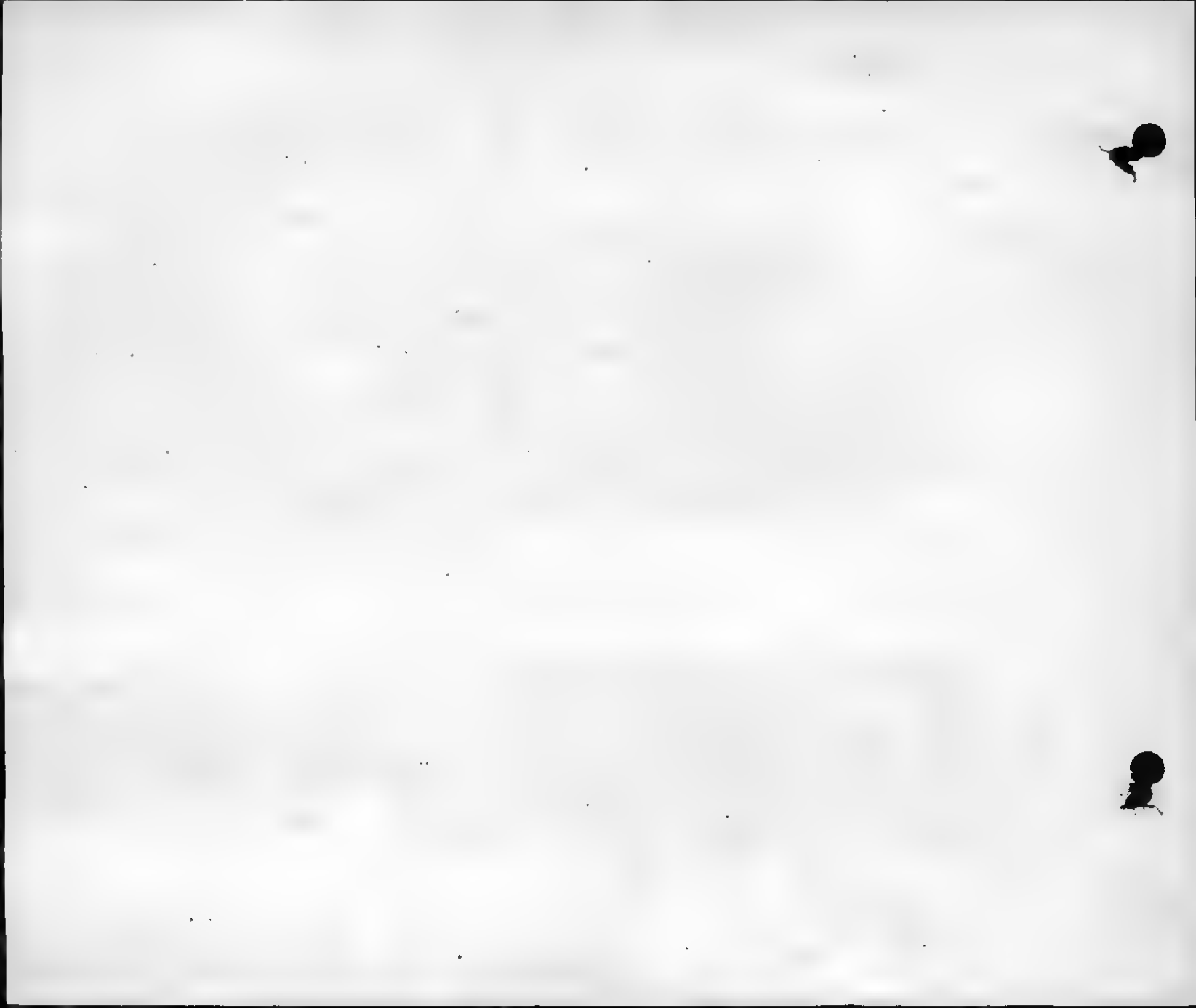
CERTIFICATE OF DEATH

00341

Reg. Dist. No. 00233

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>PARKVILLE</u>	<u>20 yrs.</u>	TOWN <u>PARKVILLE</u>	
HOSPITAL, OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>3310 Willoughby Road.</u>	<u>3310 Willoughby Road</u>		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
<u>LULA E. ROLLISON</u>		<u>JAN. 3 - 1962</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>F</u>	<u>White</u>	<u>MARRIED</u>	<u>Sept 27 - 1904</u>
9. AGE last birthday		10. IF UNDER 1 YEAR	
<u>57</u> yrs.		Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		<u>—</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>GEORGE F. ALIERS</u>		<u>Not known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>215-05-9458</u>	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
<u>Earl V. Rollison</u>		<u>3310 Willoughby Rd</u>	
<u>14</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A)		<u>Central Hemorrhage</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B)		<u>Hypertension</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 57</u> to <u>Jan. 1962</u>; that I last saw the deceased alive on <u>Dec. 27, 1961</u>, and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Rollison</u>		<u>1/4/62</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. DATE THEREOF	
<u>BURIAL</u>		<u>Jan. 6 - 1962</u>	
25. NAME OF CEMETERY OR CREMATORY		26. LOCATION (City, town, or county) (State)	
<u>Parkwood</u>		<u>Baltimore Co. Md.</u>	
27. FUNERAL DIRECTOR'S SIGNATURE		28. ADDRESS	
<u>G. Howard Strong</u>		<u>3207 North Ave</u>	





TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00343

CERTIFICATE OF DEATH
Item 2 Film G305 1/18/62 mh

00340

1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) College Manor

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 28
d. STREET ADDRESS 1009 Frederick Rd.

3. NAME OF DECEASED (Type or print) Katherine Lotta Roppersberger
First Middle Last
4. DATE OF DEATH 1 13 1962
Month Day Year

5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3/5/1877
9. AGE (In years last birthday) 84
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker
11. BIRTHPLACE (County & State; foreign country) Baltimore, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Gustave Henry Roppersberger
14. MOTHER'S MAIDEN NAME Mary C. Schaefer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mr. Gustav H. Roppersberger-5517 Roland Ave.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease
DUE TO
(c)
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Viral nasopharyngitis and Bronchitis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from September 1958 to January 13, 1962 that (I) (we) last saw the deceased alive on January 12, 1962 and that death occurred at 5:30 P.M. from the causes and on the date stated above
22a. SIGNATURE John N. Snyder M.D.
22c. PHYSICIAN'S NAME (Type) JOHN N. SNYDER M.D.
22b. DATE SIGNED January 13, 1962
22d. ADDRESS 63487 FREDERICK RD BALTIMORE MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 1-16-62
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Jim J. Schaefer Baltimore 17 Md
25a. REC'D BY REGISTRAR JAN 15 '62
25b. REGISTRAR'S SIGNATURE M. L. Thomas



CERTIFICATE OF DEATH

Reg. Dist. No.

00344

1 PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb 5 1/2 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AUGSBURG HOME		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MD b. COUNTY 1556 Waverly Hwy (12) Balt c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1556 Waverly Hwy (12) Balt d. STREET ADDRESS 6811 Campfield Rd (1) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MARY Middle ELIZABETH Last SAGER		4 DATE OF DEATH Month Jan Day 2 Year 1962	
5 SEX F	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH JUNE 8 1874
9 AGE (In years last birthday) 82 yrs		10 IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	11 IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) WYOMING		12. CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Jacob S. BOWERS		14 MOTHER'S MAIDEN NAME SUSAN MELLINGER	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO <input type="checkbox"/>	
INFORMANT F.W. KATZ		Address 6811 Campfield	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (1) Cerebral Hemorrhage 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (2) Hypertensive Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 8 hrs 5 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/14 , 19 59 , to Jan 2 , 19 62 that I last saw the deceased alive on Jan 1 , 19 62 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl L. Chambers		ADDRESS (Street, city or town, state) 4108 Liberty Hts Baltimore 7 Md	
PHYSICIAN'S NAME (Type) Earl L. Chambers		DATE SIGNED 1/2/62	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Bethwood		22d. LOCATION (City, town, or county) (State) Baltimore Md	
22e. FUNERAL DIRECTOR'S SIGNATURE W. Steinhilber		ADDRESS 6067 Hayford Rd	
24a. REC'D BY REGISTRAR JAN 5 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 10342

00345

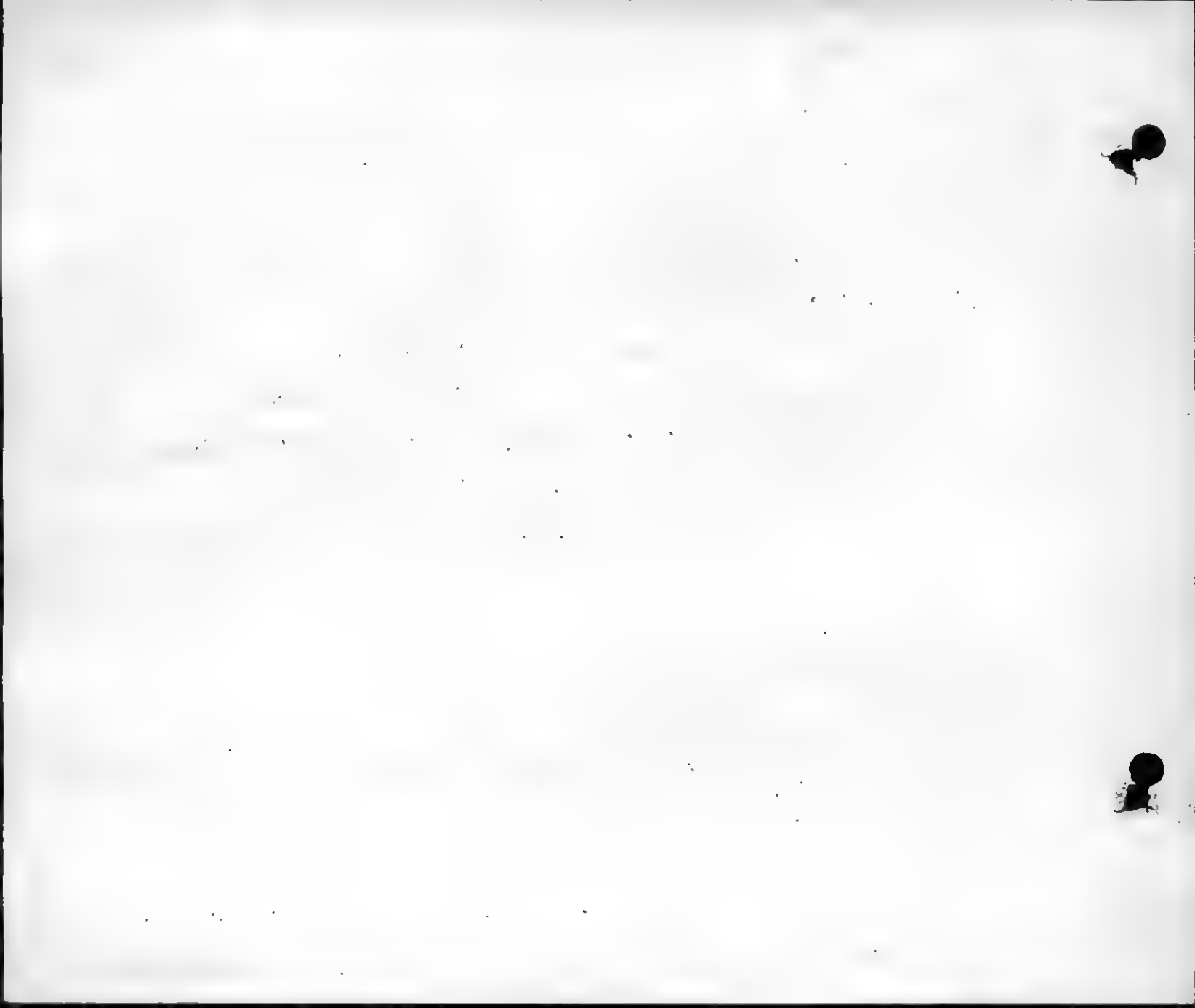
1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3630 Coronado Rd. Zone 7		1 d. STREET ADDRESS 3630 Coronado Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM SALGANIK		4. DATE OF DEATH Month 1/11/62 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 13, 1901
9. AGE (In years last birthday) yrs 60		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Jewelery	
11. BIRTHPLACE (State or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gershon Salganik		14. MOTHER'S MAIDEN NAME Rebecca Richmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217/32/7059	
17. INFORMANT Mrs. Mollie Salganik-- Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 days 9 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 11, 1962 to Jan 11, 1962 , that I last saw the deceased alive on Jan 11, 1962 , and that death occurred at 12 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE William H. Davis		M.D. 6512 Liberty Road Baltimore 7, Md.	
PHYSICIAN'S NAME (Type) 6512 Liberty Road		M.D. 6512 Liberty Road Baltimore 7, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/12/62	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew Cong		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC 6010 Reist Rd.		24a. REC'D BY REGISTRAR DATE JAN 17 '62	
24b. REGISTRAR'S SIGNATURE Carlton J. K...			

Page 4

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

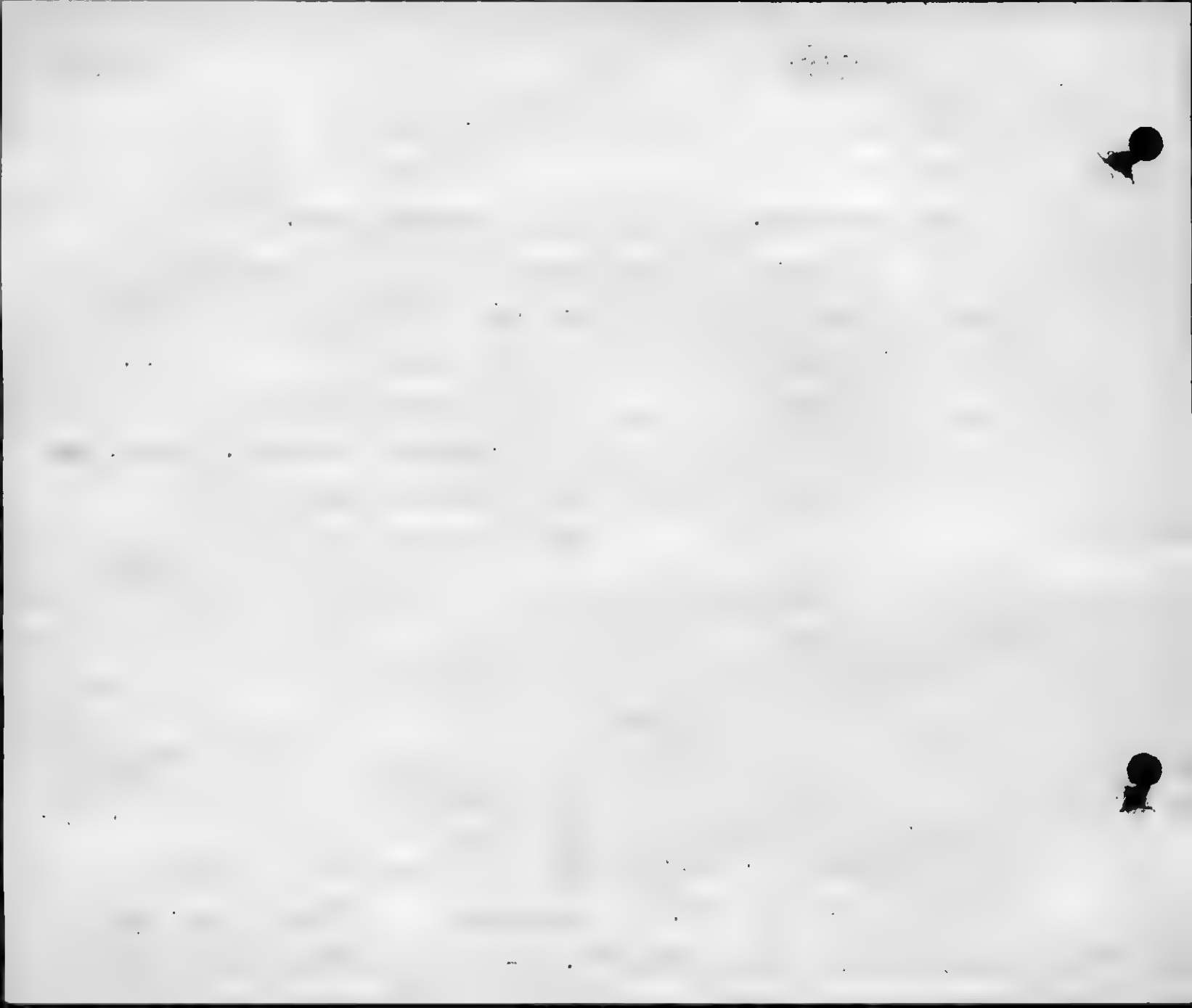


TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00346
00344

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN IN Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 403 Glenmore Ave.		d. STREET ADDRESS 403 Glenmore Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Julia Schaefer		4. DATE OF DEATH January 31 1962		Month Day Year	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 7 1880		9. AGE (In years; last birthday) 81 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (Country & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Henry Damm	
14. MOTHER'S MAIDEN NAME Barbara Jager		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 3-31-1-12	
17. INFORMANT Paul Schaefer-60 Bliss Lane, N. Wilberham, Mass		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardio-Vascular Disease DUE TO cause listed. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 da 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-31-1-12 to 1-31-1-12 , 1962 that (I) (we) last saw the deceased alive on 1-31-1-12 1962, and that death occurred 2:40 P.M. from the causes and on the date stated above.		22a. SIGNATURE Wilmer K. Gallagher 22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.		22b. DATE SIGNED 2-1-62	
22d. ADDRESS 6209 Frederick Ave., Balt. 28, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-1962	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Church Cemetery		23d. LOCATION (City, town or county) Fulton, Howard Co.; Md.		23e. REC'D BY REGISTRAR 2-5-62	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Maci		24b. ADDRESS 301 Frederick Rd. -28-		24c. REGISTRAR'S SIGNATURE John J. Maci	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00345

00347

1. PLACE OF DEATH a. COUNTY BALTO. CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD. b. COUNTY Limiting	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONS VILLE		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN E. SCHAEFER		4. DATE OF DEATH JAN 27, 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30, 1879
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CUSTODIAN		10b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-12-2265	
17. INFORMANT MADELINE SCHAEFER		Address 900 ELMRIDGE AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0. Arteriosclerosis Generalized DUE TO (b) Decubitus Ulcers hips DUE TO (c) & low Back Marked Spine		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1960 , 19, to 1/17/62 , that I last saw the deceased alive on 1/16/62 , and that death occurred at 5:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W E Mc Greth M.D.		DATE SIGNED 1/19/62	
PHYSICIAN'S NAME (Type) W E Mc Greth M.D.		ADDRESS (Street, city or town, state) 1303 Frederick Rd Catonsville 28 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 20, 1962	
22c. NAME OF CEMETERY OR CREMATORY IMMANUEL LUTHERAN		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chaworth Jr.		ADDRESS 3617 Chestnut AVE.	
24a. REC'D BY REGISTRAR JAN 23 '62		24b. REGISTRAR'S SIGNATURE Andrew S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician's office for a period of 30 days after this certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00348
00346

1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville
c. LENGTH OF STAY IN It Parkville
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 0212 veryreen drive

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parkville
d. STREET ADDRESS 0212 veryreen drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Mrs. Josephine Schleibaum
4. DATE OF DEATH January 20th 1962
5. SEX Female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ B. DATE OF BIRTH July 31, 1886
9. AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) 75 yrs. Months 8 Days 19 Hours 02 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY Scotland 11. PLACE OF BIRTH Scotland 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph illdridge 14. MOTHER'S MAIDEN NAME Mary M. Dermott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ☐ 16. SOCIAL SECURITY NO. 1-22-62 17. INFORMANT Mrs. Norman Filler 0225 veryreen drive. Address 0225 veryreen drive.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery disease
DUE TO arteriosclerosis with cardiovascular changes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized arteriosclerosis
DUE TO arteriosclerosis
(c) arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 3-29-1946 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 14 N Easton - 24 20f. (City or town, County, State) Baltimore, Maryland

21. I certify that () (this hospital) attended the deceased from 3-29-1946 to 1-20-1962 that (I) (we) last saw the deceased alive on 1-18-1962, and that death occurred at 11AM, from the causes and on the date stated above.

22a. SIGNATURE John J. Goulet 22b. DATE SIGNED 1-22-62
22c. PHYSICIAN'S NAME (Type) JOHN J. GOULET 22d. ADDRESS 14 N Easton - 24

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-24-62 23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 23d. LOCATION (City, town or county) (State) Baltimore, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5305 Harford Road #14 25a. REC'D BY REGISTRAR JAN 24 1962 25b. REGISTRAR'S SIGNATURE William E. Thomas



FOR STATE
HEALTH DEPT.

TO DEPUTY: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

(M)

14

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00349 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00349											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 3mth17dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if last full one: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville, Maryland d. STREET ADDRESS 4105 Colby Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Kathryn M. Schmitt						4. DATE OF DEATH January 2 1962					
5. SEX female						6. COLOR OR RACE white					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH Dec. 27, 1884					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) Pennsylvania						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Joseph Nicholas Borzner						14. MOTHER'S MAIDEN NAME Mary Yerg					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown						16. SOCIAL SECURITY NO unknown					
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old and new subdural hematomas DUE TO (b) Frequent falls DUE TO (c) Old age and senility											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Cerebral arteriosclerosis											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell getting out of bed on 11-7-61 and sustained hematoma in the occipital region with small abrasion.											
20c. TIME OF INJURY Month, Day, Year 11-7-61 Hour a.m. 11:35x											
20d. INJURY OCCURRED <input type="checkbox"/> at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> hospital											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catonsville 28, Maryland											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED 1-2-62											
ACTUAL SIGNATURE Joseph R. Gladue M.D.											
EXAMINER'S NAME (Type) Joseph R. Gladue, M.D.											
22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/6/62 22c. NAME OF CEMETERY OR CREMATORY Hillside 22d. LOCATION (City, town, or country) (State) Andover Pa											
23. FUNERAL DIRECTOR Frank H. Howell, Peter & son ADDRESS											
24. REC'D BY REG STRAR DATE 4 '62 24b. REGISTRAR'S SIGNATURE Arthur S. Howard											



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00350

00348

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb <u>7yr9mth23dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>none</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Welcome, Maryland</u> d. STREET ADDRESS <u>25 x 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Aggie</u> Middle <u>(M.M.)</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>19 62</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 15, 1876</u>
9. AGE (In years last birthday) <u>85 yrs.</u>		10. AGE (In years last birthday) <u>85 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vernon R. Scott</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clara Mattingly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: MRS G GROVE ST E HOSPITAL</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arteriosclerotic cardiovascular disease</u> DUE TO <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 16, 1953</u> to <u>Jan. 9, 1962</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Jan. 9, 1962</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachslar</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		22b. ADDRESS <u>SPRING GROVE ST. H. CATONSVILLE 28, Maryland</u>	
22d. DATE <u>1-9-62</u>		22e. ABOVE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/12/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Ignatius Church Cemetery, Hill Top, Maryland</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald Funeral Home, Inc.</u> 24a. ADDRESS <u>in Hart Funeral Home, Inc., Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 16 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Robert L. Thomas</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00351

CERTIFICATE OF DEATH

00349

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridge Way Manor Nursing Home</u>		d. STREET ADDRESS <u>Ridge Way Manor Nursing Home</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Seldon</u> Last <u>Ats</u>		4. DATE OF DEATH <u>January 13, 1962</u>	
5. SEX <u>Female</u>		6. AGE (In years, if under 1 year; if under 24 hours, last birthday) <u>80</u> yrs. <u>13</u> months <u>13</u> days	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Separated</u>		8. ATE OF BIRTH <u>9-21-1881</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>England</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Russell</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Fred Weisgal-10 E. Fayette Street</u>	
17. INFORMANT <u>Mr. Fred Weisgal-10 E. Fayette Street</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Heart Disease</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Disease</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 13, 1962</u> to <u>Jan. 14, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 13, 1962</u> and that death occurred at <u>12</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Leon A. Kochman</u>		22b. DATE SIGNED <u>1-13-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Leon A. Kochman</u>		22d. ADDRESS <u>1214 N. Calvert St. Baltimore 2 Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-16-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Luckert & Sons Baltimore 17 Md</u>		25a. REC'D BY REGISTRAR <u>17 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00352

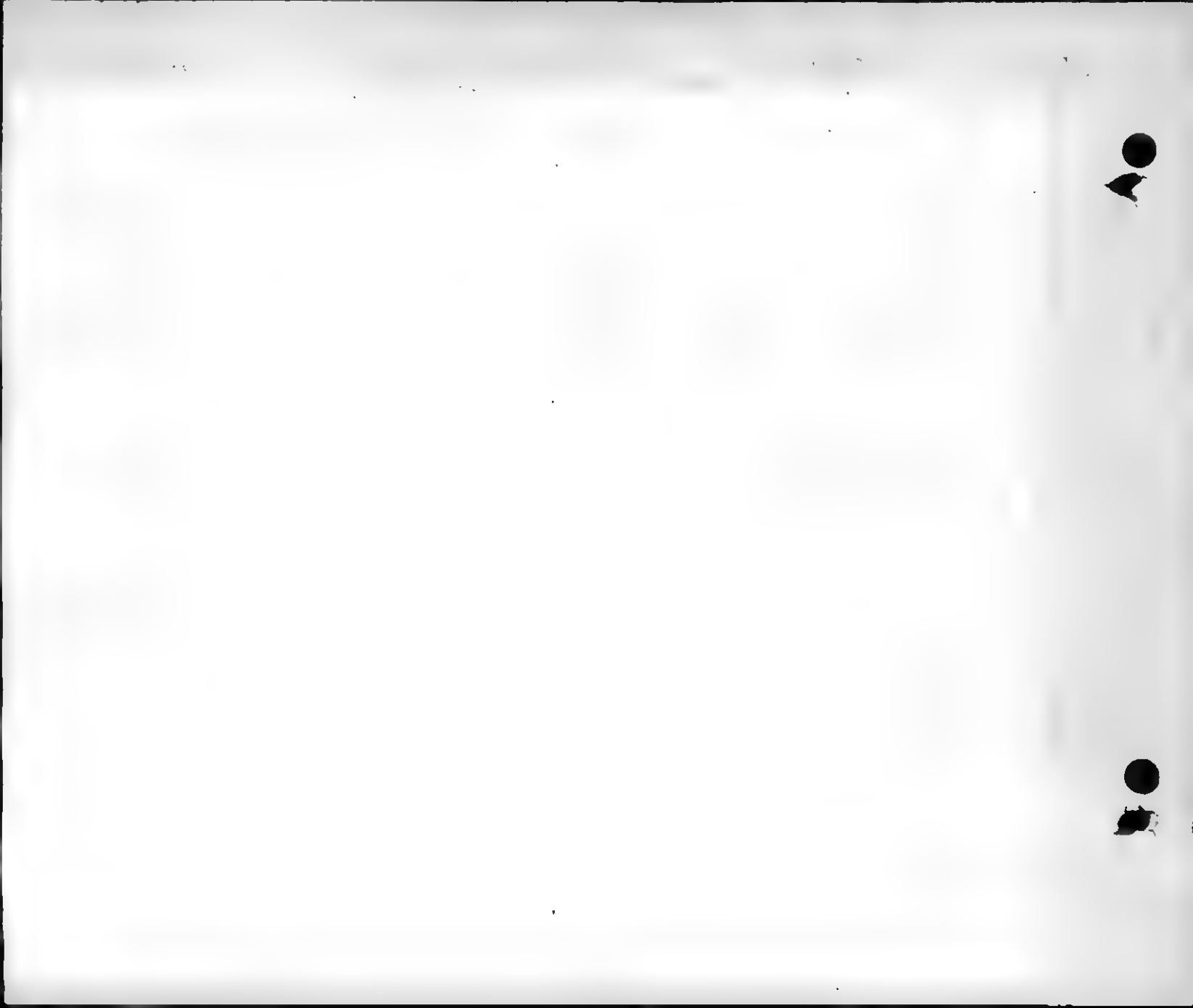
CERTIFICATE OF DEATH

Item 4 Film Group 1/31/62 iwk

00350

1. NAME OF DECEASED (Type or Print) KATHERINE A. CLARK SHEESLEY		2. DATE OF DEATH 1/20/62	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Mery Villa Bellona Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY WV C. CITY OR TOWN Baltimore 66. 18, Md. D. STREET ADDRESS 5612 Woodmont Ave. Mery Villa-6800 Bellona Ave.	
5. SEX Female	6. COLOR or RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 9/18/1880
9. AGE (In years last birthday) 81		10. UNDER 1 Year Months 1 Days 10	11. UNDER 24 Hours Hours 10 Min. 10
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10. B. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? ---	
13. FATHER'S NAME THOMAS CLARK		14. MOTHER'S MAIDEN NAME KATHERINE NORTON	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mr. J.N. Flynn-5516 Woodmont Ave. 12		ADDRESS ---	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 422.1 Broncho pneumonia DUE TO Arteriosclerotic cardio vascular disease DUE TO --- DUE TO ---			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ---			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT ---			
21. IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN		22. DATE OF OPERATION	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. I certify that (I) (the hospital) attended the deceased from December 24, 1961 to January 19, 1962 , that (I) (we) last saw the deceased alive on January 18, 1962 , and that in (my) (our) opinion death occurred at 6:00 A.M. , from the causes and on the date stated above.			
26. SIGNATURE Philip A. Flynn ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M D		27. ADDRESS 11 E. Chase Street	
28. DATE SIGNED 1-22-62		29. BUREAU OF HEALTH DEPT. JAN 23 62	
30. BURIAL, CREMATION, REMOVAL (Specify) Burial		31. DATE 1/23/62	
32. NAME OF CEMETERY or CREMATORY Cathedral Cemetery		33. LOCATION (City, town, or county) (State) Balto. City	
34. DATE REC'D BY HEALTH DEPT. JAN 23 62		35. NAME OF REGISTRAR ---	
36. FUNERAL DIRECTOR WIEDEFELD & SON-Greenmount & 22nd		ADDRESS ---	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital as attending physician and completely filled in by the funeral director. Page 2 of 2 retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of 2 could be detailed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

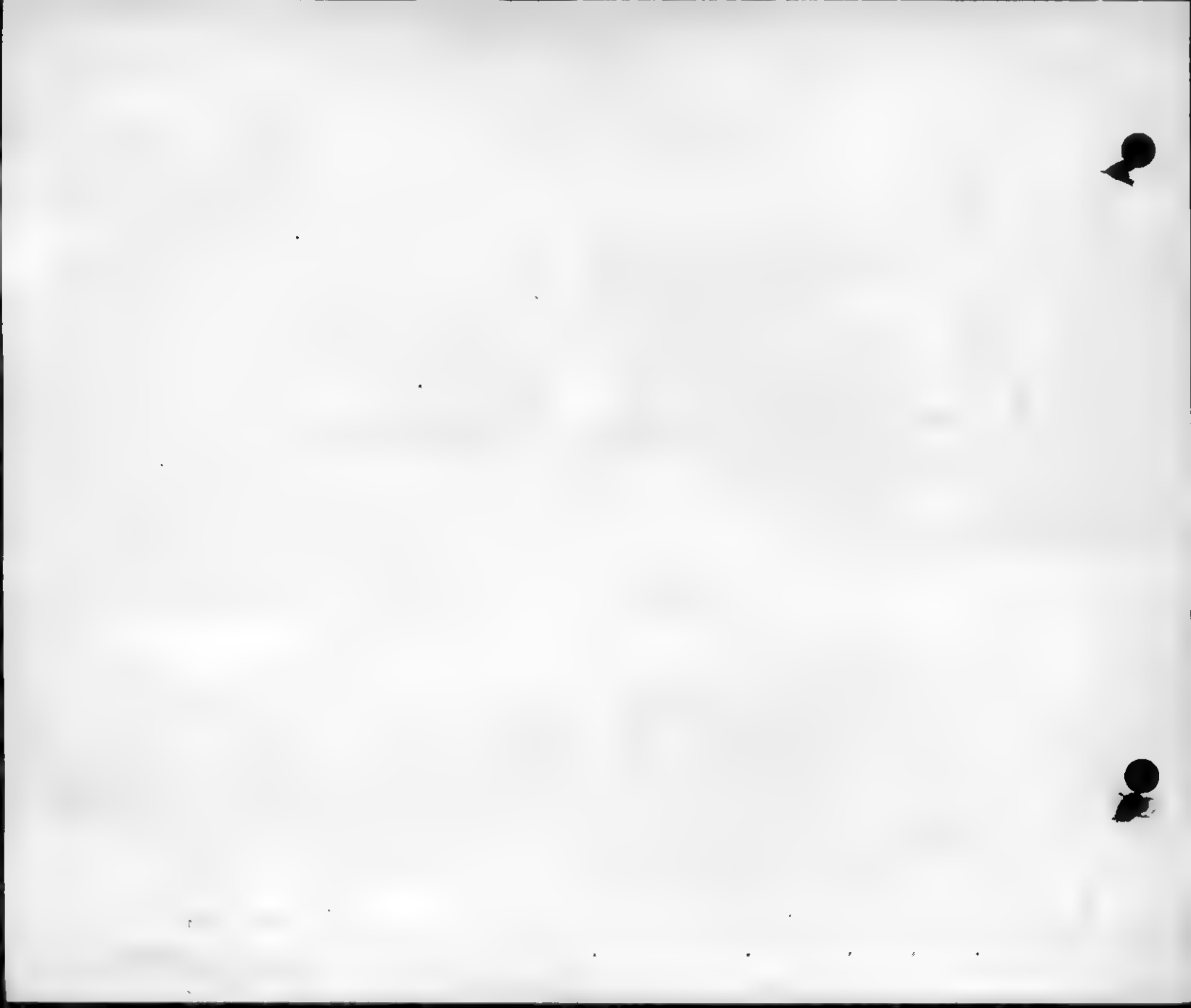

 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00353

00351

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville				c. LENGTH OF STAY IN 1b 13 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Md. Masonic Home				d. STREET ADDRESS 4315 Springdale Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norman Cecil Short				4. DATE OF DEATH January 6 1962			
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 29, 1895	
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Marine-Baltimore		11. BIRTHPLACE (State or foreign country) England	
13. FATHER'S NAME James Short				14. MOTHER'S MAIDEN NAME Sarah Watson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 209-05-5830		17. INFORMANT Masonic Home Records - Cockeysville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral broncho pneumonia							6 d.
DUE TO (b) Pulmonary edema - emphysema							6 d.
DUE TO (c) Arteriosclerotic cardiovascular disease							years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 19 1961 to Jan 6 1962 that (I) (not) last saw the deceased alive on Jan 6 1962 , and that death occurred at 2 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Elizabeth B. Sherrill				M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/6/62	
22c. PHYSICIAN'S NAME (Type) Elizabeth B. Sherrill MD.				22d. ADDRESS Cockeysville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-10-62		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Baltimore				25a. REC'D BY REGISTRAR JAN 9 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00354

00352

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OWINGS MILLS c. LENGTH OF STAY IN b. 7 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ROSEWOOD STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 113 E. FRANKLIN STREET	
3. NAME OF DECEASED (Type or print) KATHY SUE SHRADER		4. DATE OF DEATH Last SHRADER Month 1 Day 22 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		9. AGE (in years last birthday) 2 yrs. IF UNDER 1 YEAR: Months 11 Days 22 IF UNDER 24 HRS.: Hours 11 Min. 22	
11. BIRTHPLACE (County & State or foreign country) WASHINGTON - MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD Shrader		14. MOTHER'S MAIDEN NAME SARAH ELLEN WEBB	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. HOSPITAL CHART	
17. INFORMANT HOSPITAL CHART Address			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1-3 (c) 1-3 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) Microcephaly, spastic quadriplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from... May 4, 1961 , to Jan. 22, 1962 , that (if) (we) last saw the deceased alive on... Jan. 22, 1962 , and that death occurred at... 3:25 PM , from the causes and on the date stated above.			
22a. SIGNATURE Edward J. Mathews		22b. DATE SIGNED 1-22-62	
22c. PHYSICIAN'S NAME (Type) EDWARD J. MATHEWS		22d. ADDRESS Rosewood State Training School Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/24/62	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Hagerstown		25a. REC'D BY REGISTRAR Mr. Wm. G. Stoot	
25b. REGISTRAR'S SIGNATURE		DATE JAN 25 '62	

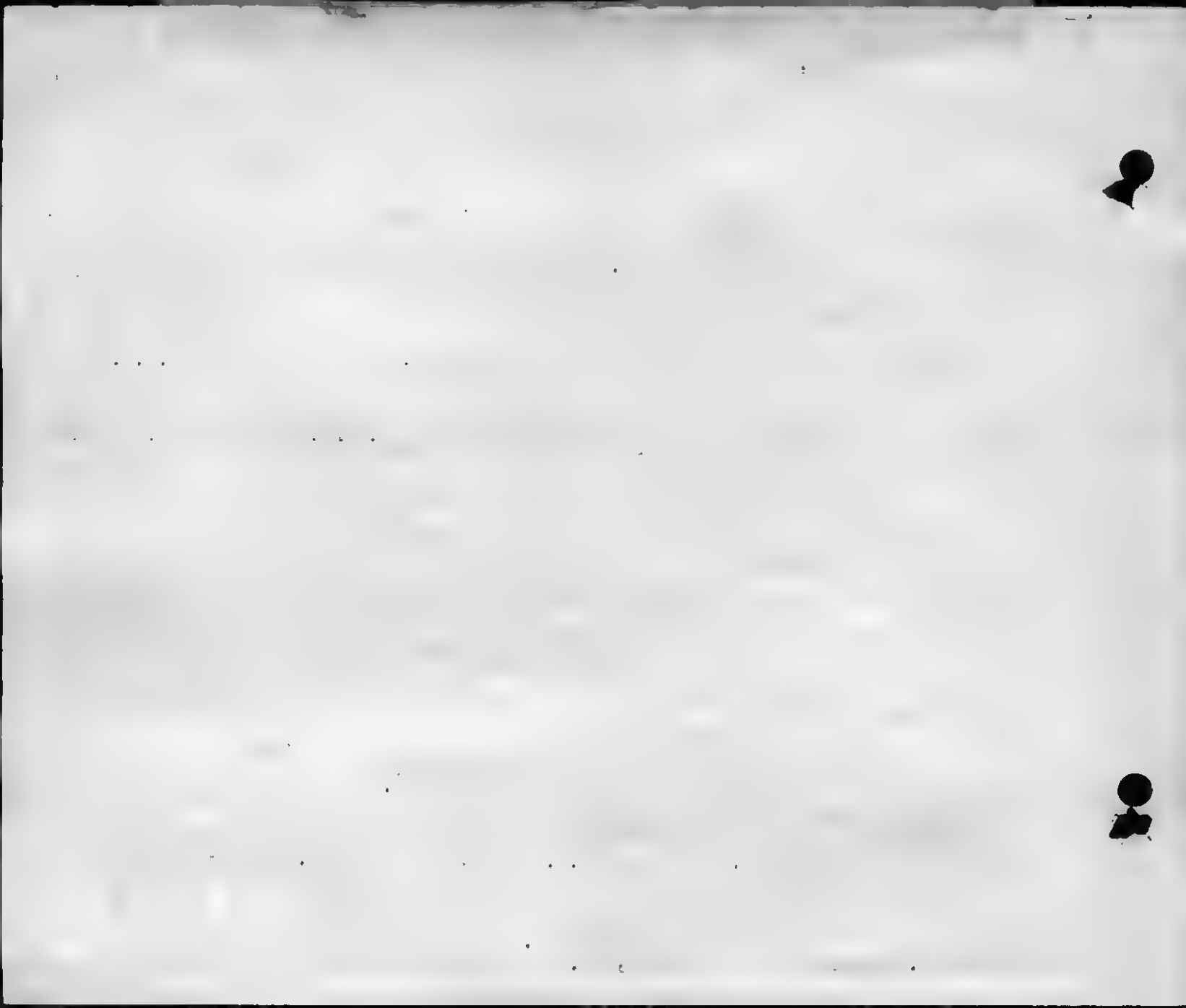


TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 1, retained by the hospital or attending physician. Page 2, retained by the funeral director. Page 3, retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00355
00353

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN b 10 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore 17		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 17		d. STREET ADDRESS 2031 McCulloh Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Howard T. Smith		4. DATE OF DEATH January 5 19 62		5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 18 1904		9. AGE (in years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef-Cook		10b. KIND OF BUSINESS OR INDUSTRY Restuarant		11. BIRTHPLACE (County & State, or foreign country) Kissimmee, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Daisy Moore		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 263-10-8243		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, acute (b) Left lower lobe pneumonia (c) Hypertensive cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal ulcer Gastric ulcer		INTERVAL BETWEEN ONSET AND DEATH 12 Days UNKNOWN UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Dec. 26, 1961 to Jan. 5, 1962, that (we) last saw the deceased alive on Jan. 5, 1962, and that death occurred at 9:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE Frederick S. Donaldson M.D.		22b. DATE SIGNED 1/6/62		22c. PHYSICIAN'S NAME (Type) FREDERICK S. DONALDSON, M.D.		22d. ADDRESS VAH, Balto. 18 Md., Ft Howard Division		23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/9/62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ELROY O. WILSON		25a. REC'D BY REGISTRAR JAN 9 '62		25b. REGISTRAR'S SIGNATURE L. H. H. H.		25c. ADDRESS 1000 Brantley Ave. Baltimore, Md.		25d. DATE		25e. SIGNATURE		25f. ADDRESS		25g. DATE		25h. SIGNATURE	



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00356

00354

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b. 569 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if Institutions Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 723 Harford Avenue	
3. NAME OF DECEASED (Type or print) WILLIAM WILLIE SMITH SMITH		4. DATE OF DEATH January 20 19 62	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25, 1899	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Waggam, Louisiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Smith		14. MOTHER'S MAIDEN NAME Josephine Bush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA DUE TO LAENNEC'S CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) D/D DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year July 30 19 62 Hour a.m. 11:15 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that JOHN D. TALBERT (this hospital) attended the deceased from July 30 19 62 to January 20, 19 62 , that he (we) last saw the deceased alive on January 20 19 62 , and that death occurred 11:15 M, from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D. Medical Service		22b. DATE SIGNED 1/22/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-26-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR JAN 31 '62	
25b. REGISTRAR'S SIGNATURE C. L. S. Kraus			



TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 is retained by the hospital or attending physician. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

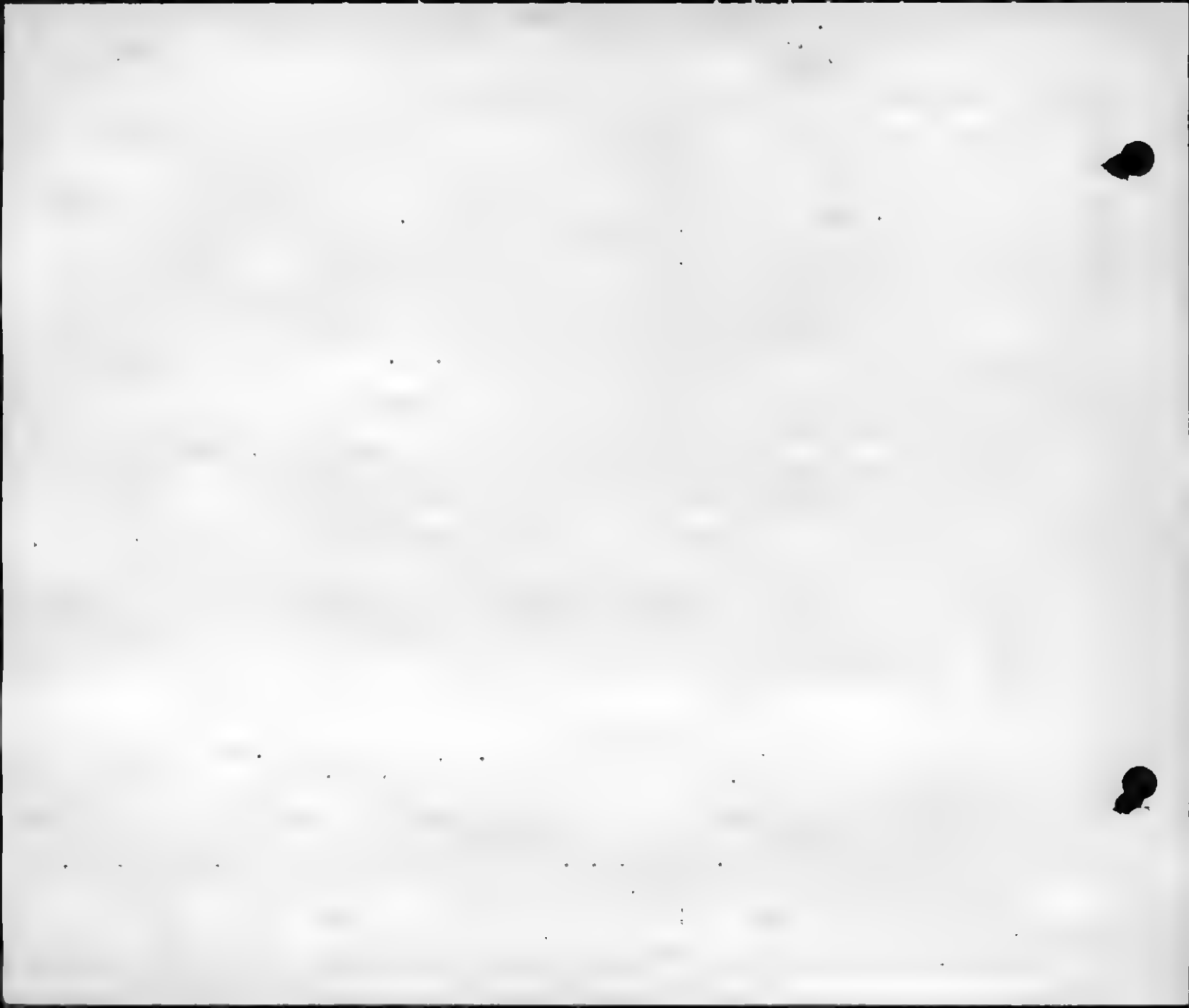
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00357

CERTIFICATE OF DEATH

00355

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN life Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3510 E. Joppa Road		e. STREET ADDRESS 3510 E. Joppa Road		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William I Snyder		4. DATE OF DEATH 1 21 1962		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-29-1888	
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building		11. BIRTHPLACE (County & State, or foreign country) Balto. Co. Md	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Isaac Snyder		14. MOTHER'S MAIDEN NAME Elizabeth Prigel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go on or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-01-5734		17. INFORMANT Mrs Jessie G Snyder 3510 E. Joppa Rd 16	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis DUE TO Adenocarcinoma of stomach CONDITIONS, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 months 9-12- Mo.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 17, 1961 to Jan. 21, 1962 that (I) (we) last saw the deceased alive on Jan. 21, 1962, and that death occurred at 10:15 P.M. from the causes and on the date stated above.		22a. SIGNATURE Theodore E. Evans, M.D.		22b. DATE 1-22-62	
22c. PHYSICIAN'S NAME (Type) Theodore E. Evans, M.D.		22d. ADDRESS 9660 Belair Road, Balto 6, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-25-1962		23c. NAME OF CEMETERY OR CREMATORY Fork Meth Cemetery	
23d. LOCATION (City, town or county) Fork		23e. (State) Md		24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road	
25a. REC'D BY REGISTRAR DATE JAN 26 '62		25b. REGISTRAR'S SIGNATURE L. J. Evans		25c. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00358

CERTIFICATE OF DEATH

00356

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rosedale</u> c. LENGTH OF STAY IN 1b <u>3 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1321 Pine Grove Ave.</u>		2 USUAL RESIDENCE (Where deceased lived) f. Institution Residence before admission a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rosedale</u> d. STREET ADDRESS <u>1321 Pine Grove Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Marie F. Margaret Soistman</u>		4. DATE OF DEATH Month Day Year <u>Jan. 15 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22 1985</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Fuller</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Schreiber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-09-1771</u>	
17. INFORMANT Name Address <u>Herbert M. Soistman 1321 Pine Grove Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), starting the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 1960</u> to <u>January 15, 1962</u> , that I last saw the deceased alive on <u>Jan 15, 1962</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Gith</u>		DATE SIGNED <u>Jan 16, 1962</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Coach</u>		ADDRESS <u>124 Chesaco Ave.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-18-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Coach</u>		24a. RECEIVED BY REGISTRAR DATE <u>JAN 18 1962</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

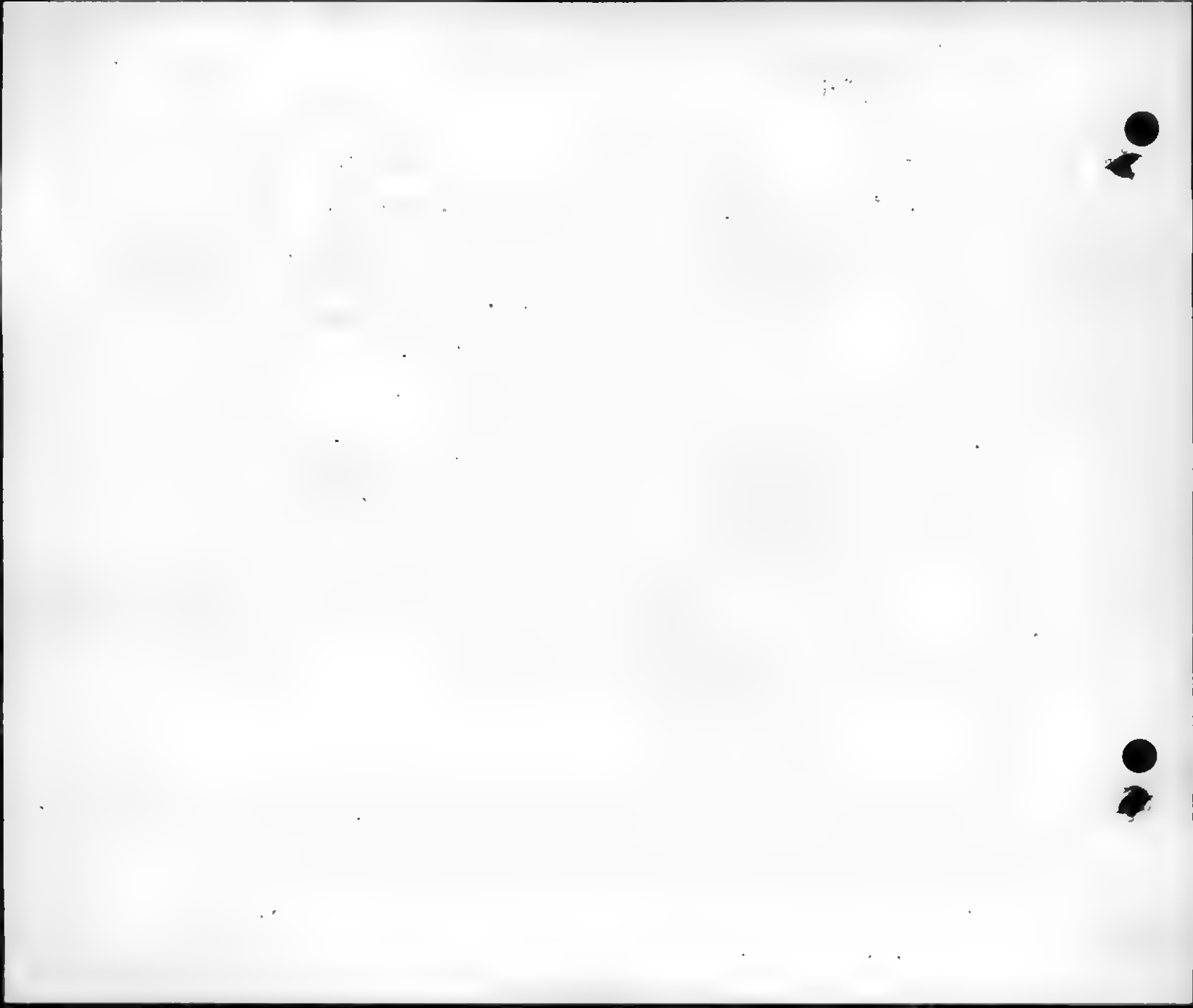
00357

00359

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home		d. STREET ADDRESS St. Johns Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AUGUST Middle SONNTAG Last		4. DATE OF DEATH Month January Day 25 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 15, 1885
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 12 Days 25 Hours 19 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Chicken	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Forest Haven Records	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EMBOLISM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EMBOLISM (c) ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - PULMONARY EMBOLISM		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/1 , 1961, to 1/25 , 1962, that I last saw the deceased alive on 1/25 , 1962, and that death occurred at 9:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Shaw M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 5501 E. HUNTERS AVE. 1/26/62	
PHYSICIAN'S NAME (Type) John H. Shaw M.D.		B.O. No. 28, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-29-62	22c. NAME OF CEMETERY OR CREMATORY Good Shepherd	22d. LOCATION (City, town, or county) (State) Ellicott City, Md
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham		24a. REC'D BY REGISTRAR JAN 29 '62	
ADDRESS Ellicott City, Md		24b. REGISTRAR'S SIGNATURE John H. Shaw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00358

00350

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6528 CORKLEY Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARYANNA Middle SPOCHACZ Last SPOCHACZ		4. DATE OF DEATH Month JANUARY Day 8 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 7-1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? POLAND	
13. FATHER'S NAME MICHAEL CHMIELEWSKI		14. MOTHER'S MAIDEN NAME MARGARET CHES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-9046	
17. INFORMANT Address AGNES KRUS-6528 CORKLEY Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial hypertension Disease + 43X DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Atrial fibrillation (b) (c)			INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 1-3-62 , 19 62 , to Jan. 3-1962 , that I last saw the deceased alive on 1-3- , 19 62 , and that death occurred at 4:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. John Geldrich		ADDRESS (Street, city or town, state) 8019 Philadelphia Road Baltimore 6, Maryland	
PHYSICIAN'S NAME (Type) John Geldrich, M.D.		DATE SIGNED	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/10/62	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	22d. LOCATION (City, town, or county) (State) 6515 Boston St-Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber 705 S. Ann st		24a. REC'D BY REGISTRAR JAN 9 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Knecht

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00361

CERTIFICATE OF DEATH

00359

1. PLACE OF DEATH a. COUNTY <u>BALTO Co</u> <u>27</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO HIGHLANDS</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2838 TENNESSE AV.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO HIGHLANDS</u> d. STREET ADDRESS <u>2838 TENNESSE AV.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>NETTIE R. STANKO</u>		4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1962</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-1895</u> <u>66</u> yrs.		19. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Mon <u>1</u> Days <u>16</u> Hours <u>16</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>BUTMAN'S</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>John P. Stanko</u>				17. INFORMANT <u>Abner</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4-1-3X</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)																20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>OCT. 13, 1957</u> to <u>JAN. 16, 1962</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>JAN. 13, 1962</u> , and that death occurred at <u>Home</u> , from the causes and on the date stated above.																			
22a. SIGNATURE <u>C. Arthur Rossberg MD</u> M.D.																ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG MD</u>																22d. ADDRESS <u>2436 WASHINGTON BLVD</u>		<u>BALTO-30</u>	
23a. BURIAL, CREMATION, RECOVERY (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-19-62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Glenn Haven Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Glenn Burnie, MD</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Luman & Son Inc. Balto 23, MD</u> ADDRESS																25a. REC'D BY REGISTRAR <u>JAN 18 62</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Carroll S. Haines</u>	

TO HOSPITAL OR FUNERAL HOME: This certificate must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00362

00360

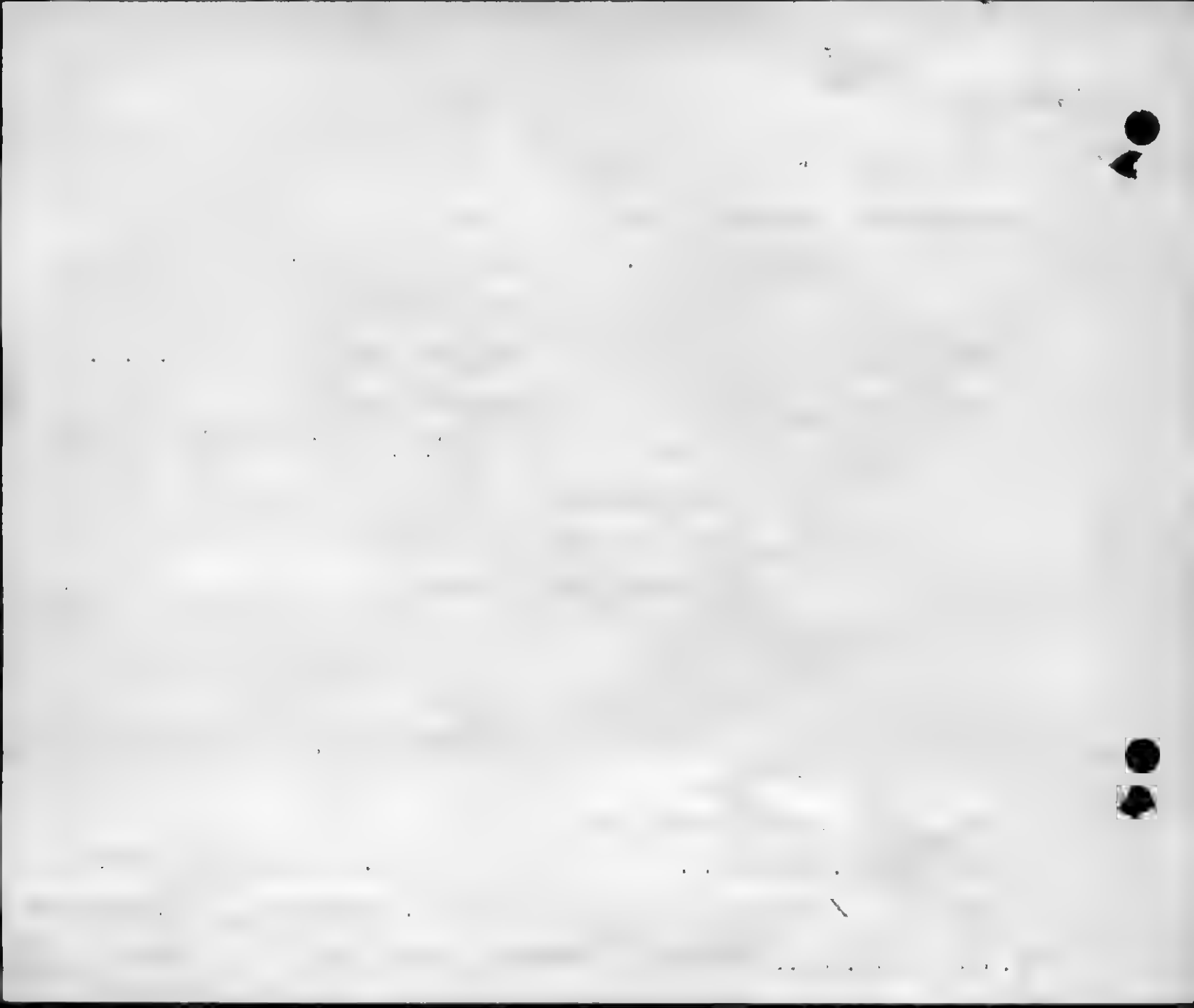
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>13 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>11</u> d. STREET ADDRESS <u>2719 Huntington Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>BERNARD M. STARR</u>		4. DATE OF DEATH Month <u>January</u> Day <u>3</u> Year <u>19 62</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>James Starr</u>					
14. MOTHER'S MAIDEN NAME <u>Catherine Maker</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW I</u>					
16. SOCIAL SECURITY NO. <u>218-10-7595</u>		17. INFORMANT <u>Clinical Records, VAH, Baltimore 18, Maryland</u> <u>Fort Howard Division</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO (b) <u>ENCEPHALOMALACIA, RIGHT CEREBRUM</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>BENIGN PROSTATIC HYPERTROPHY</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (this hospital) attended the deceased from <u>December 21, 1961</u> , to <u>January 3, 1962</u> , that (I) (we) last saw the deceased alive on <u>January 3, 1962</u> , and that death occurred at <u>3:15</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Crahan</u>		22b. DATE SIGNED <u>1/13/62</u>		22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. CRAHAN, M.D.</u>			
22d. ADDRESS <u>VAH, BALTO. 18 MD FT HOWARD DIVISION</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>1-5-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore 28, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., Baltimore 14, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Curtis S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VII A (4)
 15M 1/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00363

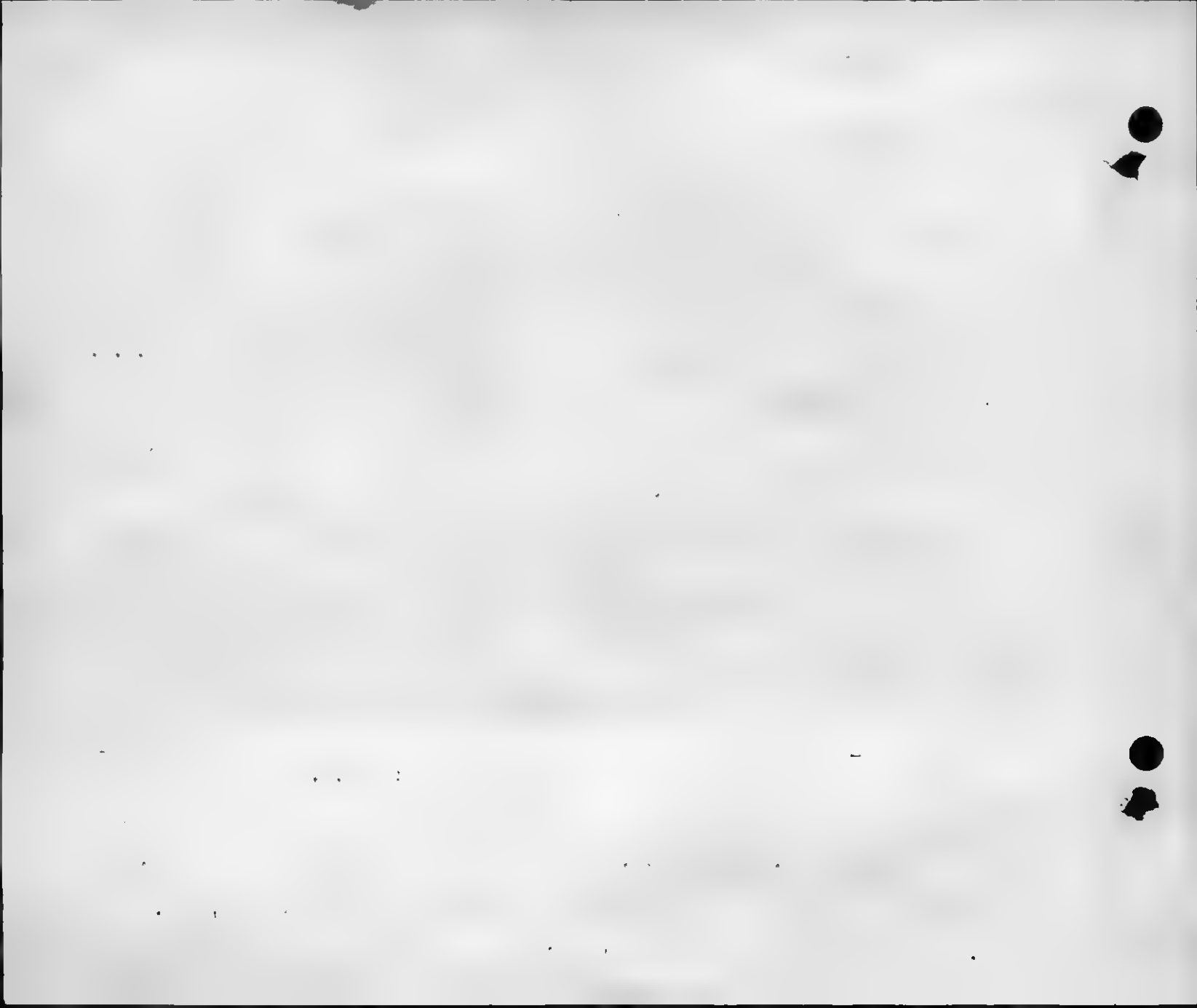
00364

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN b. <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alleghany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>1019 Frederick Street</u>	
3. NAME OF DECEASED (Type or print) <u>Barbara Jo</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/18/48</u> 9. AGE (In years last birthday) <u>13</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>18</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dependent</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE County <u>Cumberland</u> State <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Henry Stitcher</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Carmel Rosemary Stitcher</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Rosewood Records, Owings Mills, Maryland</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LCBAR PNEUMONIA (LEFT LOWER LOBE)</u> (b) <u>complicating long standing</u> (c) <u>hydrocephalus.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>12/13</u> <u>1961</u> to <u>1/18</u> <u>1962</u> , that (H) (we) last saw the deceased alive on <u>1/18</u> <u>1962</u> , and that death occurred at <u>7:45 p.m.</u> the causes and on the date stated above.			
22a. SIGNATURE <u>Harry G. Butler</u> 22c. PHYSICIAN'S NAME (Type) <u>Harry G. Butler, M.D.</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Rosewood Lane, Owings Mills, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/22/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u> ADDRESS <u>Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>John S. Hunt</u> 25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #7 - File # 100364

CERTIFICATE OF DEATH

Reg. Dist. No.

00362

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Louison</u>		c. LENGTH OF STAY IN 1b <u>17 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eastport</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Aged Women & Aged Men's Home</u>				d. STREET ADDRESS <u>417 Forth St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Amelia</u> Middle <u>C</u> Last <u>Suit</u>				4. DATE OF DEATH Month <u>January</u> Day <u>20</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/1876</u>		9. AGE (In years last birthday) <u>85</u> yrs	10. IF UNDER 1 YEAR Months <u>3</u> Days <u>10</u>	11. IF UNDER 24 HRS. Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, when retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes USA</u>	
13. FATHER'S NAME <u>David Drohan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Roach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>		INFORMANT Address <u>Sally E. Hamilton, 615 Chestnut Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerosis Cardio-vascular Disease</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Sanguine at first 48 hrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>45</u> , to <u>Jan 10</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>January 19</u> , 19 <u>62</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Newland E. Day</u>				M.D. <u>H-E-33rd St Baltimore Md Jan 20, 1962</u>			
PHYSICIAN'S NAME (Type) <u>Newland E. Day, M.D.</u>				4 East 33rd Street, Baltimore 18			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-23-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>5829 Ritchie Highway, Zone 25</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00363

00365

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>6 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maryland Masonic Home</i>		d. STREET ADDRESS <i>315 Frederick St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>Milton</i> Last <i>Sutton</i>		4. DATE OF DEATH Month <i>Jan</i> Day <i>10</i> Year <i>1962</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Aug 6, 1869</i>
9. AGE (In years last birthday) <i>92</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <i>Storekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General Store</i>	11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		13. FATHER'S NAME <i>Joseph H Sutton</i>	
14. MOTHER'S MAIDEN NAME <i>Rachel S Supler</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>217-10-7531</i>		17. INFORMANT Address <i>Records Masonic Home Cockeysville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-vascular disease</i> 4-22-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <i>Gyro. +</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 19, 1961</i> , to <i>Jan 10, 1962</i> , that (I) (we) last saw the deceased alive on <i>Jan 9, 1962</i> , and that death occurred at <i>7 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Elizabeth B. Sherrill</i> M.D.		22b. DATE SIGNED <i>1/10/62</i>	
22c. PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherrill, M.D.</i>		22d. ADDRESS <i>Cockeysville, Md.</i>	
23a. BURIAL CREMATION, etc. (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>1-13-62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Pikesville</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 2</i>		25a. REC'D BY REGISTRAR <i>JAN 11 '62</i>	25b. REGISTRAR'S SIGNATURE <i>L. Huns</i>



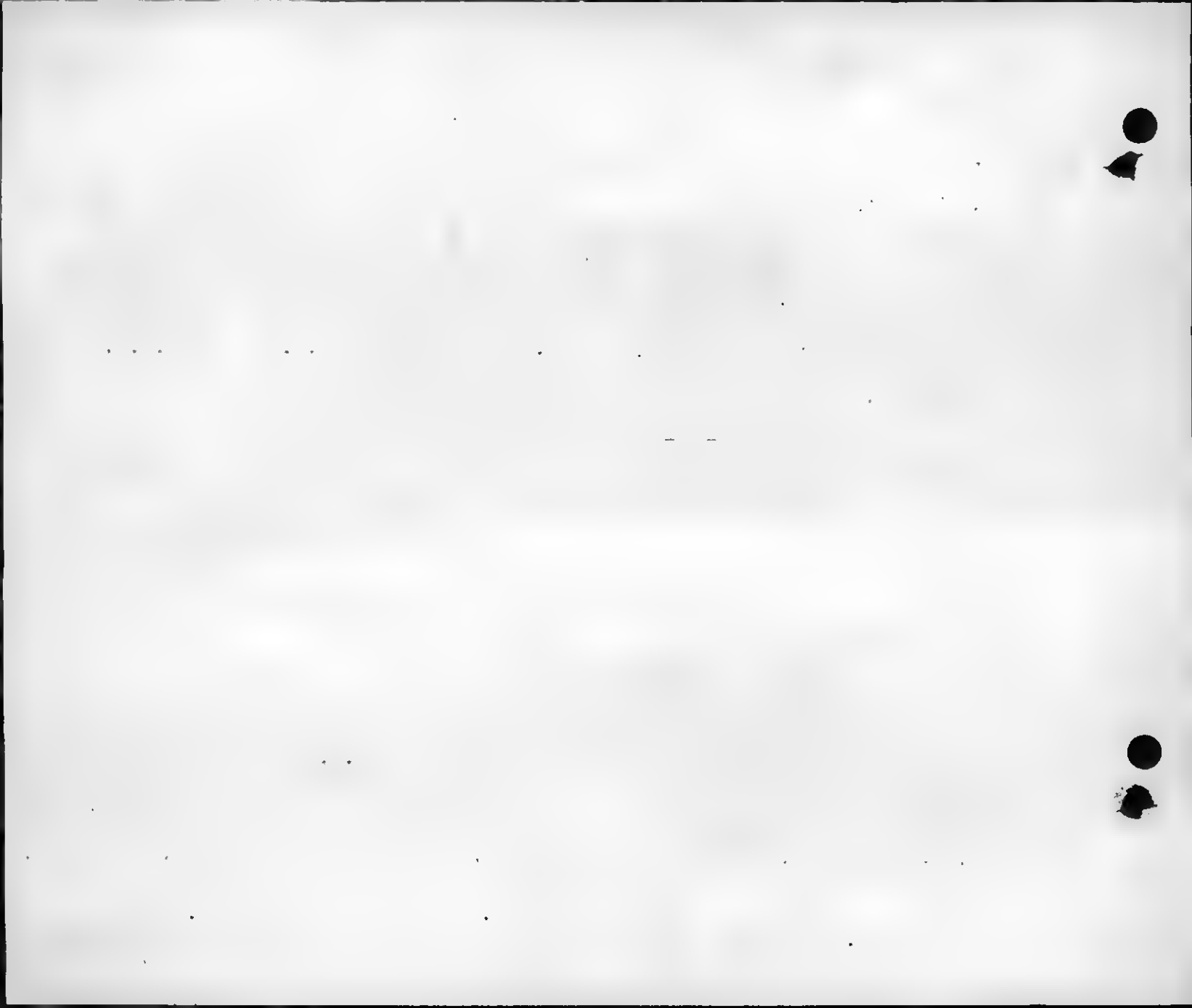
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00366

00364

1 PLACE OF DEATH a COUNTY Baltimore County MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE Maryland b COUNTY Baltimore			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c LENGTH OF STAY IN 1b 8½ months			
d NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				d STREET ADDRESS 3306 Clifftmont Avenue		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Lee Last Sweetman				4. DATE OF DEATH Month 1 Day 3 Year 19 62			
5 SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/30/1898	
9. AGE (In years last birthday) 63 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Repairman		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Sweetman				14. MOTHER'S MAIDEN NAME Katherine Lucas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 212-05-0470		17. INFORMANT Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Far Advanced Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of lung							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from 4/11/61 4:15 p.m. 1/3/62 , 19____, that (I) (we) lost saw the deceased alive on 1/3/62 19____, and that death occurred at _____ M, from the causes and on the date stated above							
22a. SIGNATURE <i>W. Newcomer</i>				22b. DATE 1/3/62		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent	
22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.				22e. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. SIGNATURE <i>W. Newcomer</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/6/62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek				25a. REC'D BY REGISTRAR DATE JAN 5 '62		25b. REGISTRAR'S SIGNATURE <i>W. Newcomer</i>	
25c. ADDRESS 3331 Brehms Lane							

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00367 Item 4 Film G305 1/11/62 jwk

00365

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Timonium

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

24 Gorsuch Road

3. NAME OF DECEASED

(Type or print)

Sarah

Elizabeth

Swint

5. SEX

Female

White

WIDOWED

DIVORCED

8. DATE OF BIRTH

Nov. 8, 1883

4. DATE OF DEATH

Month Day Year

January 5 1962

9. AGE (In years, last birthday) 78 yrs.

10. IF UNDER 24 HRS. Hours Min.

11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

11b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Georgia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

James Walker

14. MOTHER'S MAIDEN NAME

Isabelle Bealer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Carolyn S. Koenig-24 Gorsuch Road

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:

422.1 Immediate Cause (a)

AGE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Renal Failure
arteriosclerotic Cardiovascular Disease

INTERVAL BETWEEN ONSET AND DEATH

3 days

3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year 19

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from July 1957 to Jan 4, 1962, that (I) (we) last saw the deceased alive on Jan 4, 1962 and that death occurred at 7:30 M, from the causes and on the date stated above

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

GEORGE T. GILMORE, MD

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22d. ADDRESS

LANHAM BUILDING LUTHERVILLE

23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

23b. DATE THEREOF

1-6-62

23c. NAME OF CEMETERY OR CREMATORY

Powell Church Cemetery

23d. LOCATION (City, town or county)

Harlem, Georgia

24. FUNERAL DIRECTOR'S SIGNATURE

Wm J. Johnson, 9200 Baltimore Rd., Md.

25a. REC'D BY REGISTRAR

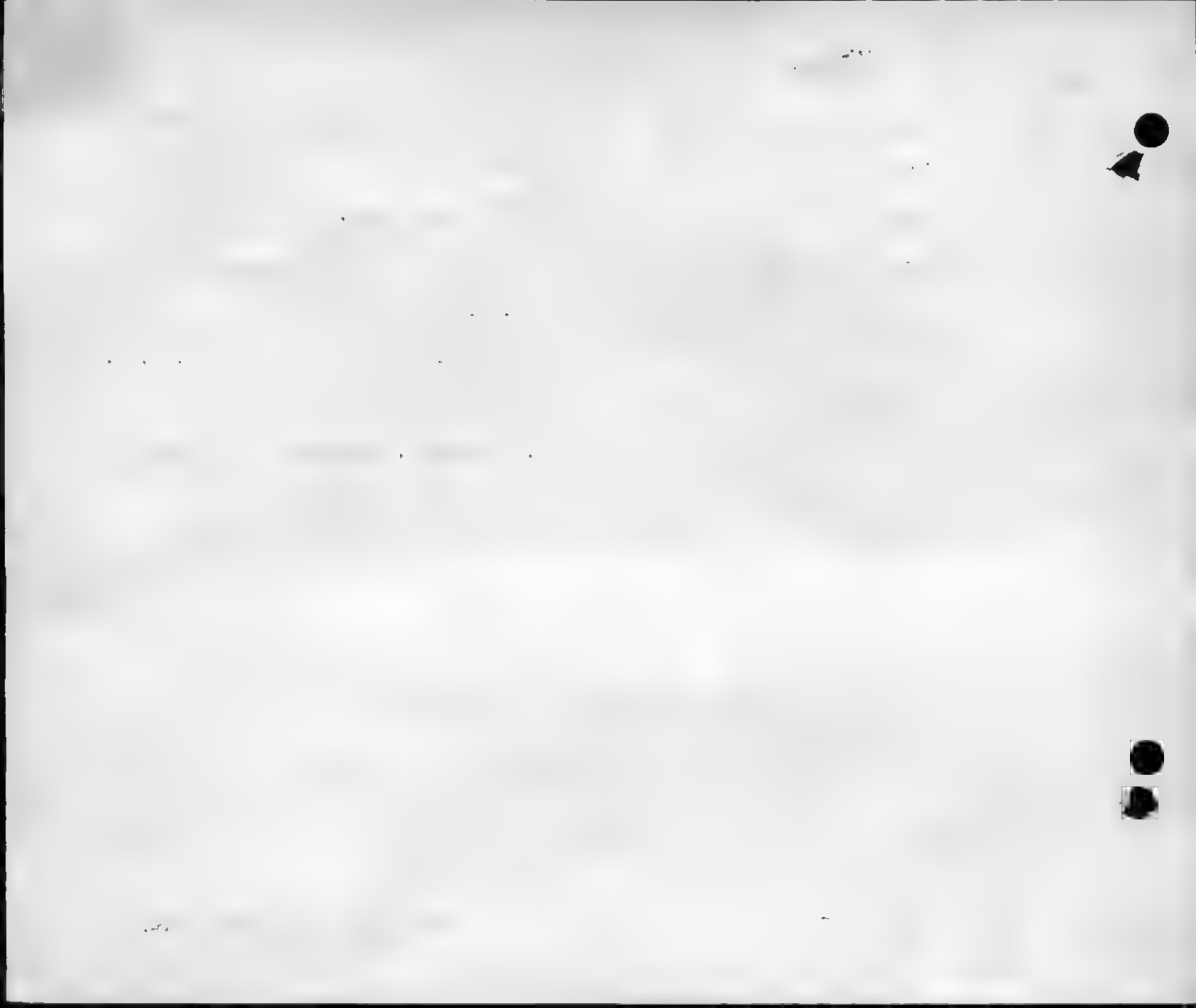
JAN 8 1962

25b. REGISTRAR'S SIGNATURE

Wm J. Johnson

TO HOSPITAL: A. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

V-115 (4)
15M 9/100



L. A. S. Kraus

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

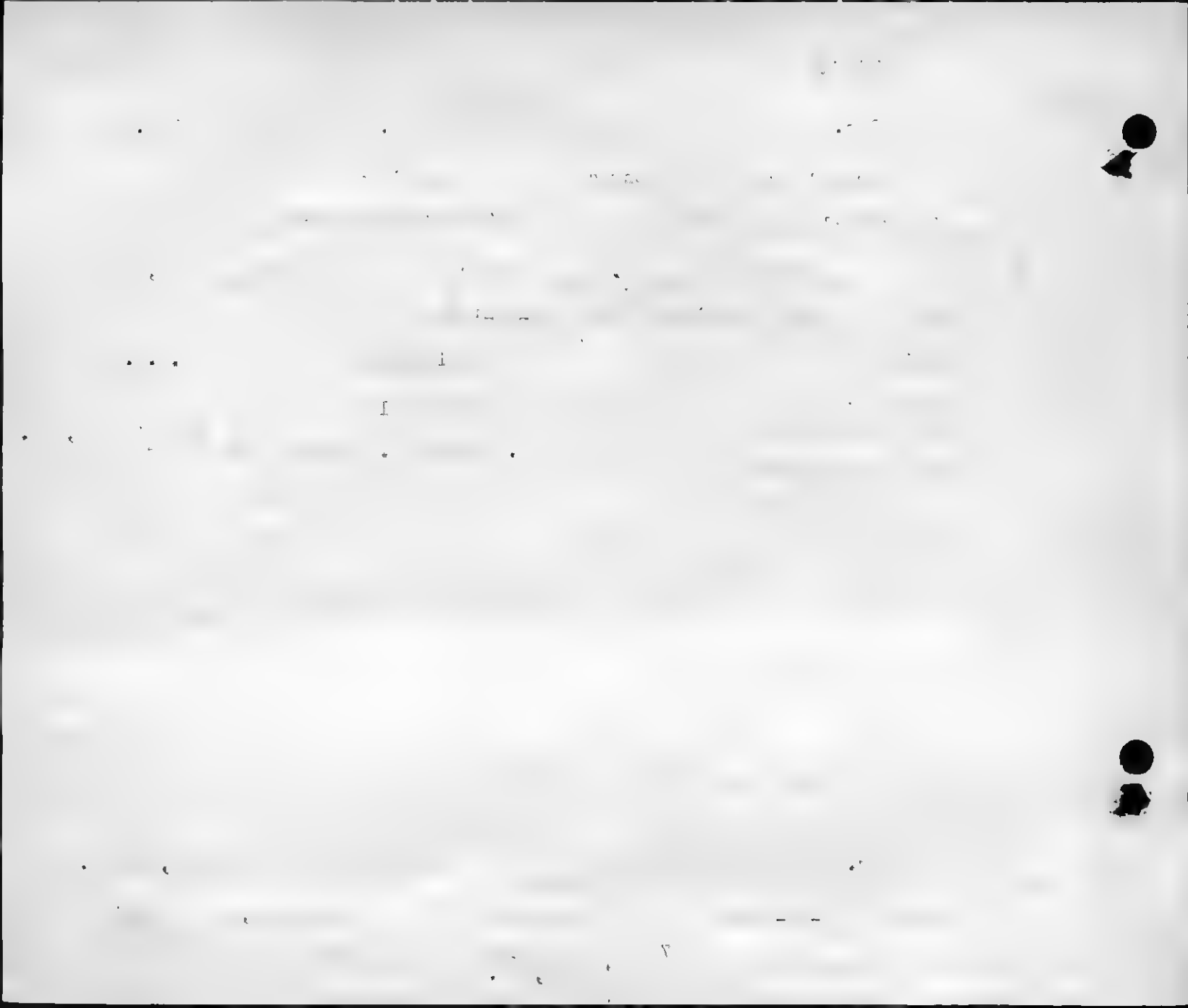
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00369

00367

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wards Chapel		c. LENGTH OF STAY IN 1b 4 Months	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Chapel Hill Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
f. STREET ADDRESS 802 Milford Mill Road		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Grace P. Tasker		4. DATE OF DEATH Jan/ 19, 19 62	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> Married		8. DATE OF BIRTH 3-14-1969	
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR: Months 10 Days 26 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Caleb Pitkin		14. MOTHER'S MAIDEN NAME Flavia Clark	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Matthew H. Bradway		Address Pikesville 8, Md. 802 Milford Mill Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary thrombosis 332 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr 10 26 21	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/2/60 , 19 60 , to 1/2/62 , 19 62 ; that (I) (we) last saw the deceased alive on 1/12/62 , 19 62 , and that death occurred at 11:00 A.M. from the causes and on the date stated above;			
22a. SIGNATURE Dr. Milton Schlenoff		22b. DATE SIGNED 1/2/62	
22c. PHYSICIAN'S NAME (Type) Dr. Milton Schlenoff		22d. ADDRESS 6410 Windsor Mill Road, Balto. 7	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 1-22-1962	
23c. NAME OF CEMETERY OR CREMATORY Valley Cemetery		23d. LOCATION (City, town or county) (State) Manchester, New Hampshire	
24. FUNERAL DIRECTOR'S SIGNATURE Living Byers		25a. REC'D BY REGISTRAR DATE JAN 24 '62	
25b. REGISTRAR'S SIGNATURE Robert S. Thomas			

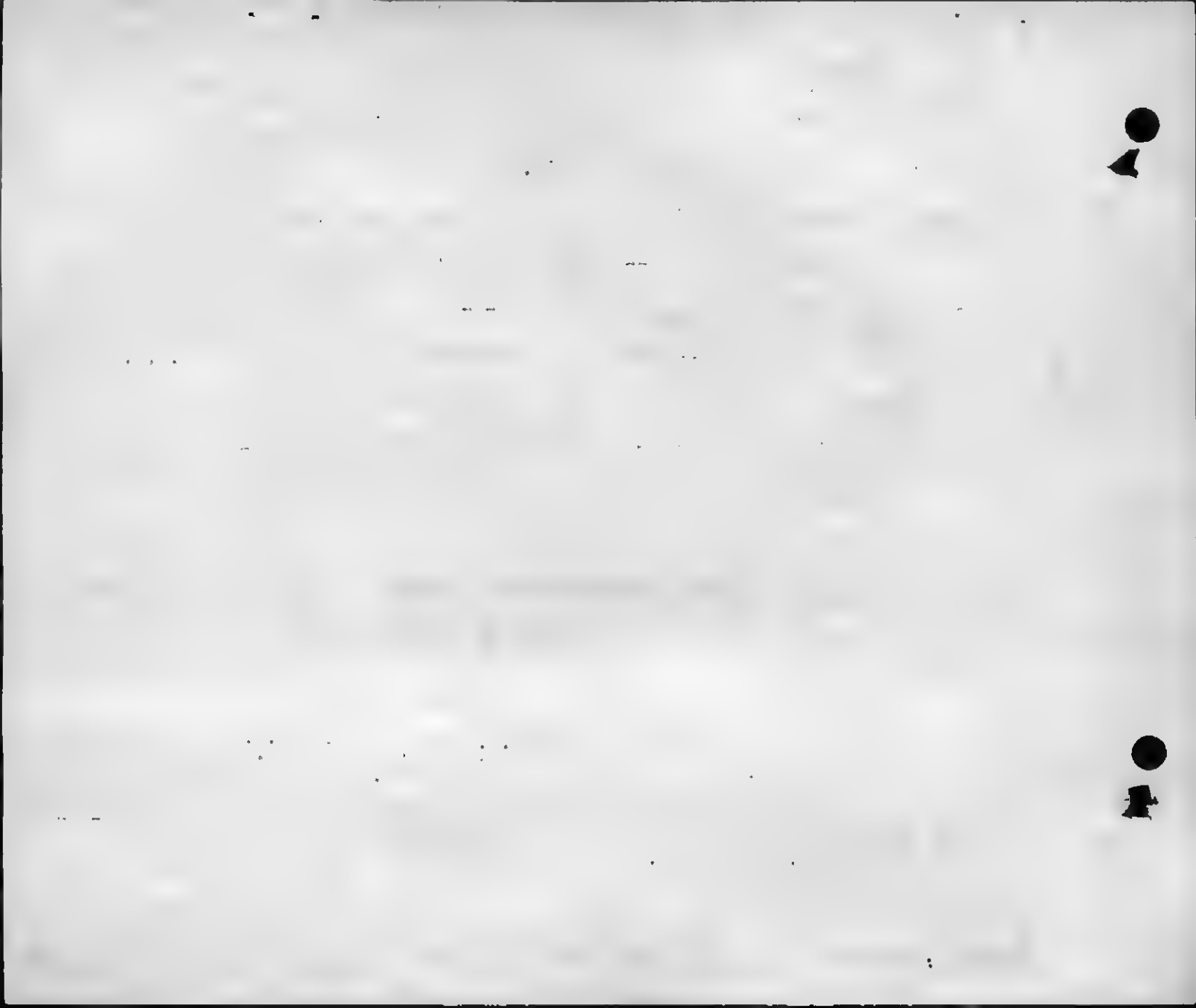


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

<div>1</div> <div>00370</div> <div>00368</div>									
<div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div>									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN 1b <u>7 Hours; 15 Min.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>321 East 24th Street</u>				
3. NAME OF DECEASED (Type or print) <u>William Taylor</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-6-89</u> 9. AGE (In years) IF UNDER 1 YEAR last birthday Months Days Hours Min. <u>72</u> yrs.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 4. DATE OF DEATH <u>January 12 1962</u> 10. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oysterman</u> 11. BIRTHPLACE County & State, or foreign country <u>Tazewell Co Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Major Taylor</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Smith</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>231-10-1012</u> 17. INFORMANT <u>Clin Rec VAH Baltimore Md - Ft Howard Division</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC PASSIVE CONGESTION OF LUNGS AND LIVER</u> (b) <u>CARDIAC INSUFFICIENCY</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAT... TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>ARTERIOSCLEROSIS, GENERALIZED. ADENOMA, TAIL OF PANCREAS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2:30 P.M. 9:45 P.M.</u> 20f. (City or town) (County) (State) <u>Baltimore</u> <u>Maryland</u>				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from... <u>Jan. 12 1962</u> to... <u>Jan. 12 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on... <u>Jan. 12 1962</u> , and that death occurred at... <u>2:43 P.M.</u> from the causes and on the date stated above.					22a. SIGNATURE <u>Ronald M. Stewart</u> M.D. 22b. DATE SIGNED <u>1-11-62</u> 22c. PHYSICIAN'S NAME (Type) <u>RONALD M. STEWART, M.D.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-17-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>					24. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> 25a. REC'D BY REGISTRAR <u>JAN 19 1962</u> 25b. REGISTRAR'S SIGNATURE <u>1. L. S. HARRIS</u>				

MEDICAL CERTIFICATION

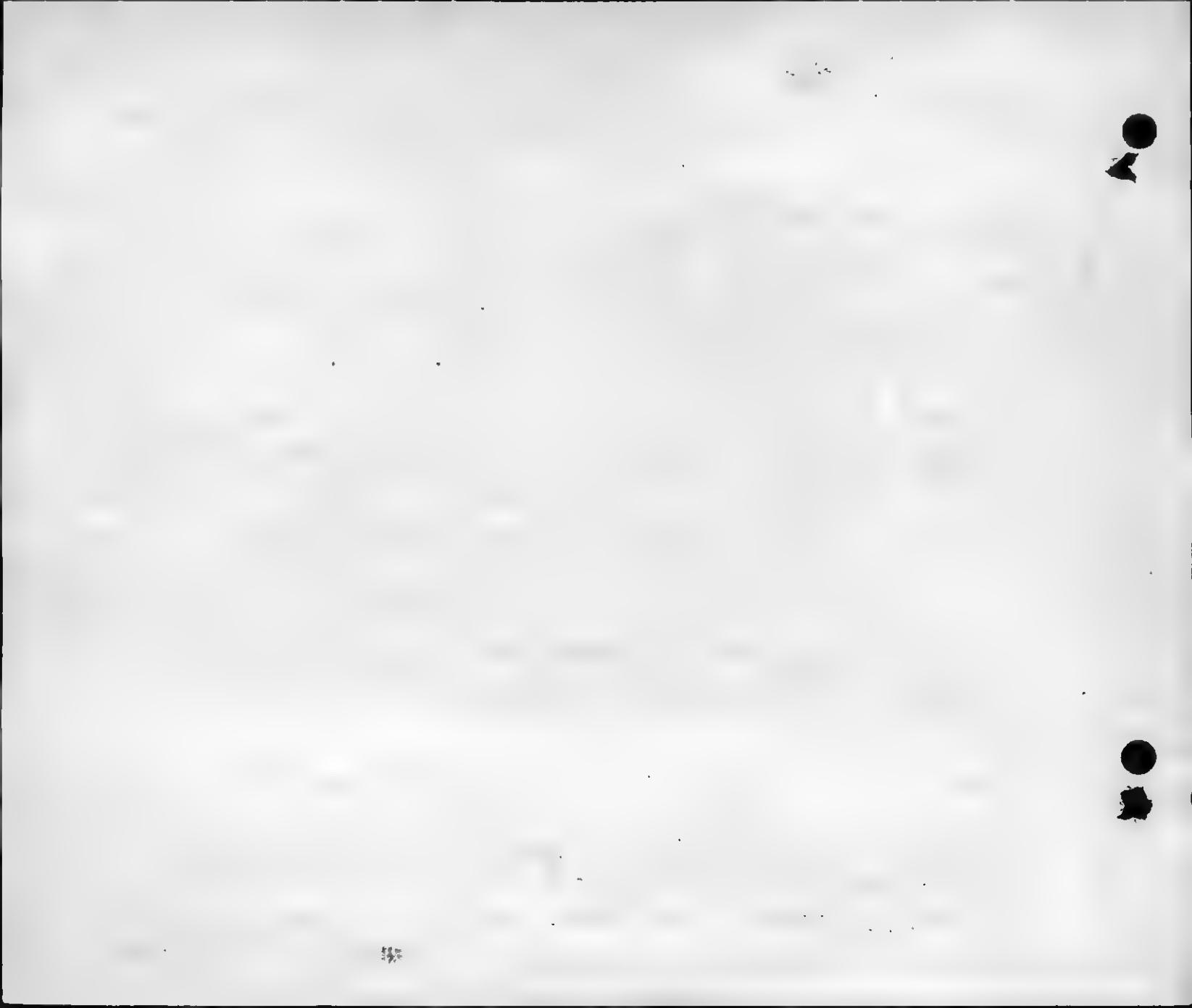


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 days after death. Page 4 should be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> c. LENGTH OF STAY IN <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4230 Chapel Road</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> d. STREET ADDRESS <u>4230 Chapel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Sebastian Thim</u>		4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-4-1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. City Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Sebastian Thim</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Rudel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes W M I</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Margaret Luckert</u>		Address <u>Perry Hall Md</u> <u>4320 Chapel Road</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-cerebral Disease</u> DUE TO (c) <u>Anteroseptal Myocardial Infarct</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>12 years</u> <u>10 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> <u>1961</u> to <u>1/2</u> <u>1962</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> <u>1961</u> , and that death occurred at <u> </u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hirschfeld M.D.</u>		22b. DATE SIGNED <u>1/4/1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN H. HIRSCHFELD M.D.</u>		22d. ADDRESS <u>6919 HARFORD Road, Balto 14 Md</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-5-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 7401 Belair Road</u>		25a REC'D BY REGISTRAR DATE <u>JAN 5 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

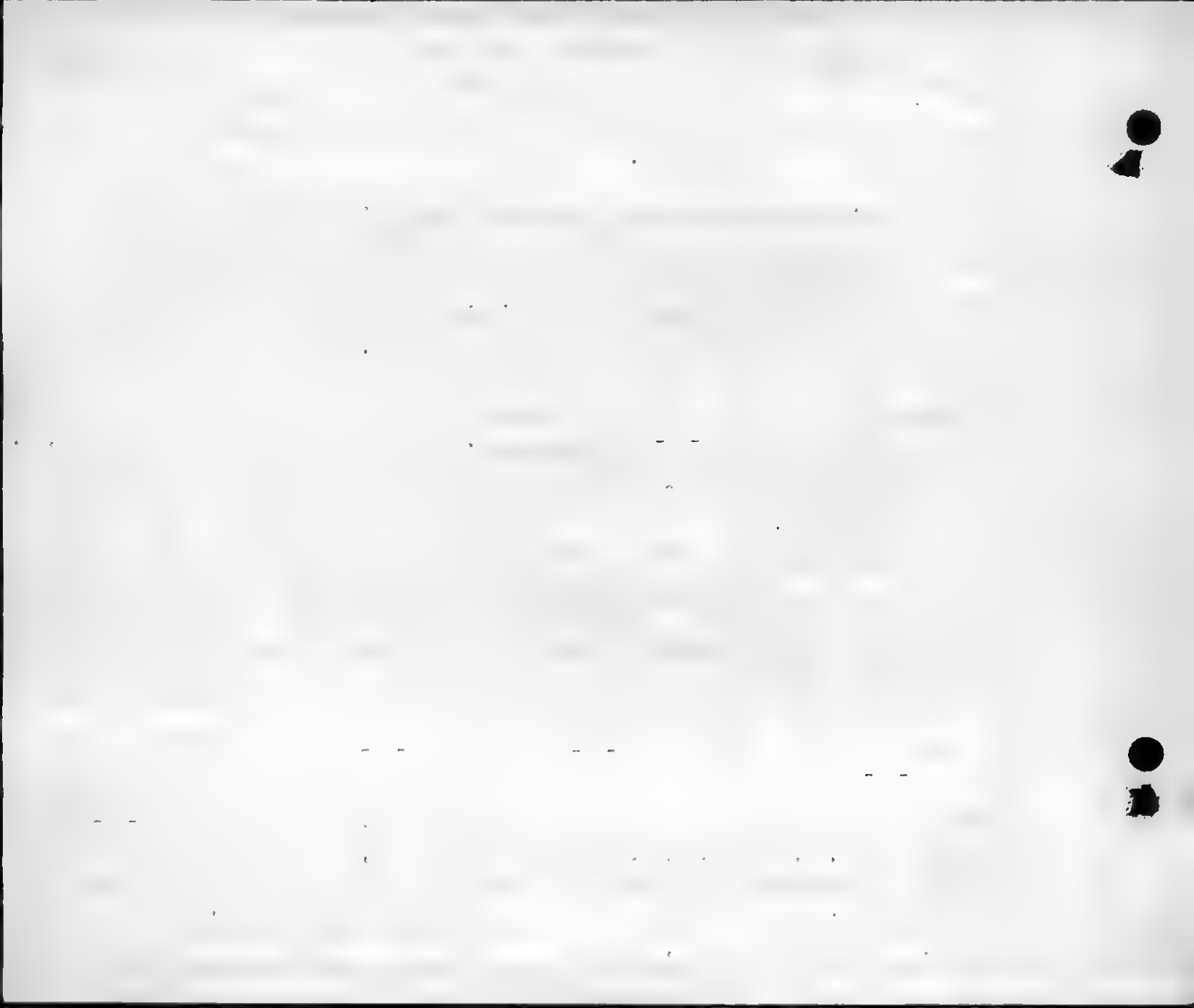
Reg. Dist. No. **00370**

00372

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boxerhill Rd.				d. STREET ADDRESS Boxerhill Rd., Box 325A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ROLAND Middle HARRISON Last THOMAS				4. DATE OF DEATH Month Jan. Day 26 Year 19 62				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18, 1889		
9. AGE (In years last birthday) yrs 72		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner			10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas				14. MOTHER'S MAIDEN NAME Catherine Stover				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			16. SOCIAL SECURITY NO 219-22-0820		17. INFORMANT Address Gladys M. Thomas, Boxerhill Rd., Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 12-22-58, 19, to 1-26-62, 19, that I last saw the deceased alive on 7-14-61, 19, and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 1-26-62								
ACTUAL SIGNATURE <i>D. D. Caples</i> M.D. 6 Hanover Rd.				DATE SIGNED 1-26-62				
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				Reisterstown, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 29, 1962		22c. NAME OF CEMETERY OR CREMATORY Druid Ridge		22d. LOCATION (City, town, or county) (State) Pikesville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Frank H. Newell, Pikesville 8, Md.				24a. REC'D BY REGISTRAR DATE JAN 30 '62		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician. This certificate has been signed by the attending physician and completely filled in by the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

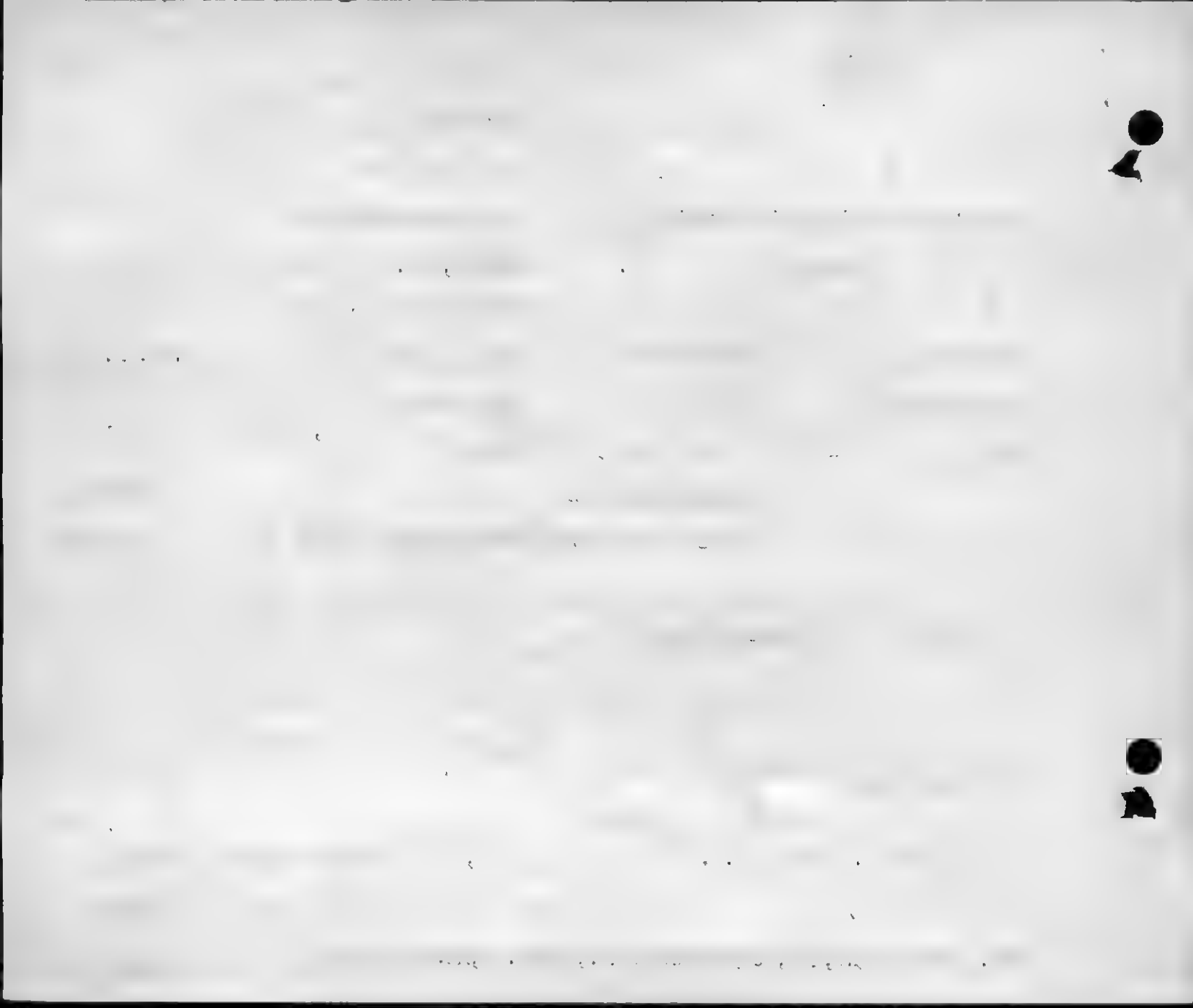
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00373

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00371

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 136 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 23 d. STREET ADDRESS 2346 Frederick Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM First H. Middle THOMPSON, SR. Last 4. DATE OF DEATH January 11 19 62 Month Day Year		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH September 17, 1897 9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) Months Days Hours Min. 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 13. FATHER'S NAME Jack Thompson		10b. KIND OF BUSINESS OR INDUSTRY Construction 11. BIRTHPLACE (County & State, or foreign country) Buffalo, New York 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II 16. SOCIAL SECURITY NO. 218-01-6345		17. INFORMANT Mary Murphy Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRAIN TUMOR (GLIOMA) BOTH FRONTAL LOBES DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) BENIGN PROSTATIC HYPERTROPHY		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from August 28 19 61 to January 11 19 62 , that (we) last saw the deceased alive on January 11 19 62 , and that death occurred at 7:35 A.M. from the causes and on the date stated above.		22a. SIGNATURE <i>Thomas F. Crahan</i> 22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D. 22b. DATE SIGNED 1/11/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-15-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery 23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md. 24a. REC'D BY REGISTRAR Jan 15 1962		25b. REGISTRAR'S SIGNATURE <i>Robert L. Hume</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is caused, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

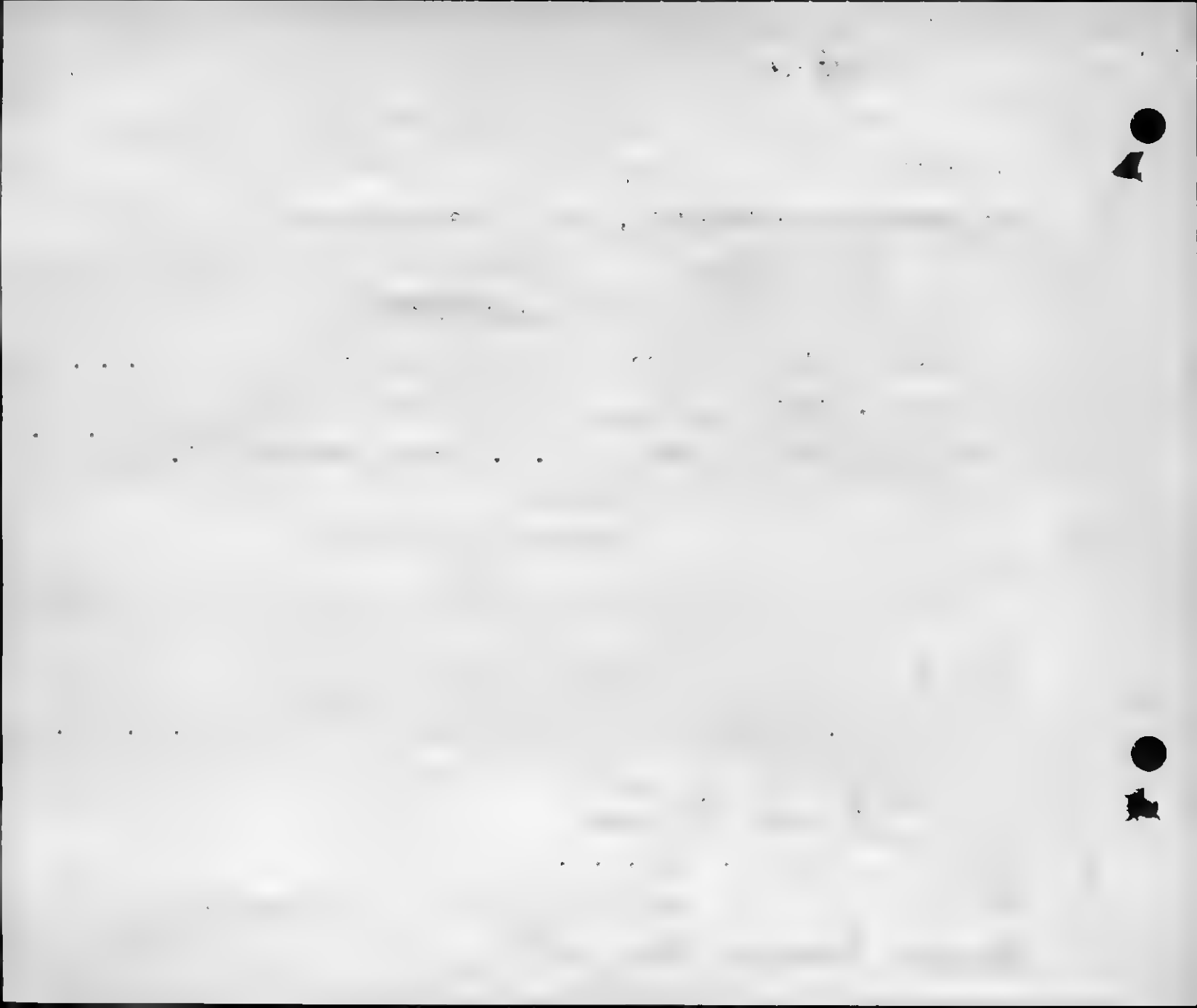
VS A1SME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville c. LENGTH OF STAY IN 1b 2 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Welford Road Lutherville, Md		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville d. STREET ADDRESS 113 Welford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GORDON 4. DATE OF DEATH January 20 19 62 5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1952 9. AGE (In years last birthday) 9 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School child 10b. KIND OF BUSINESS OR INDUSTRY school 11. BIRTHPLACE (State or foreign country) Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Raymond T. Tippitt 14. MOTHER'S MAIDEN NAME Helen Almeda Morrison 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No 16. SOCIAL SECURITY NO. None 17. INFORMANT R. B. Lownes Address Germantown Pike Lafayette, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 116.0 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. Conflagration in home 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month Day Year Jan. 20 19 62 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 113 Welford Road 20f. (City or town) (County) (State) Balto. Co. Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE Russell S. Fisher EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		DATE SIGNED January 20, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1-24-62 22c. NAME OF CEMETERY OR CREMATORY St. Timothy's Cms 22d. LOCATION (City, town, or country) (State) Philadelphia Pa.		23. FUNERAL DIRECTOR Richard D. Lownes ADDRESS Lafayette 24a. REC'D BY REGISTRAR JAN 23 '62 24b. REGISTRAR'S SIGNATURE	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

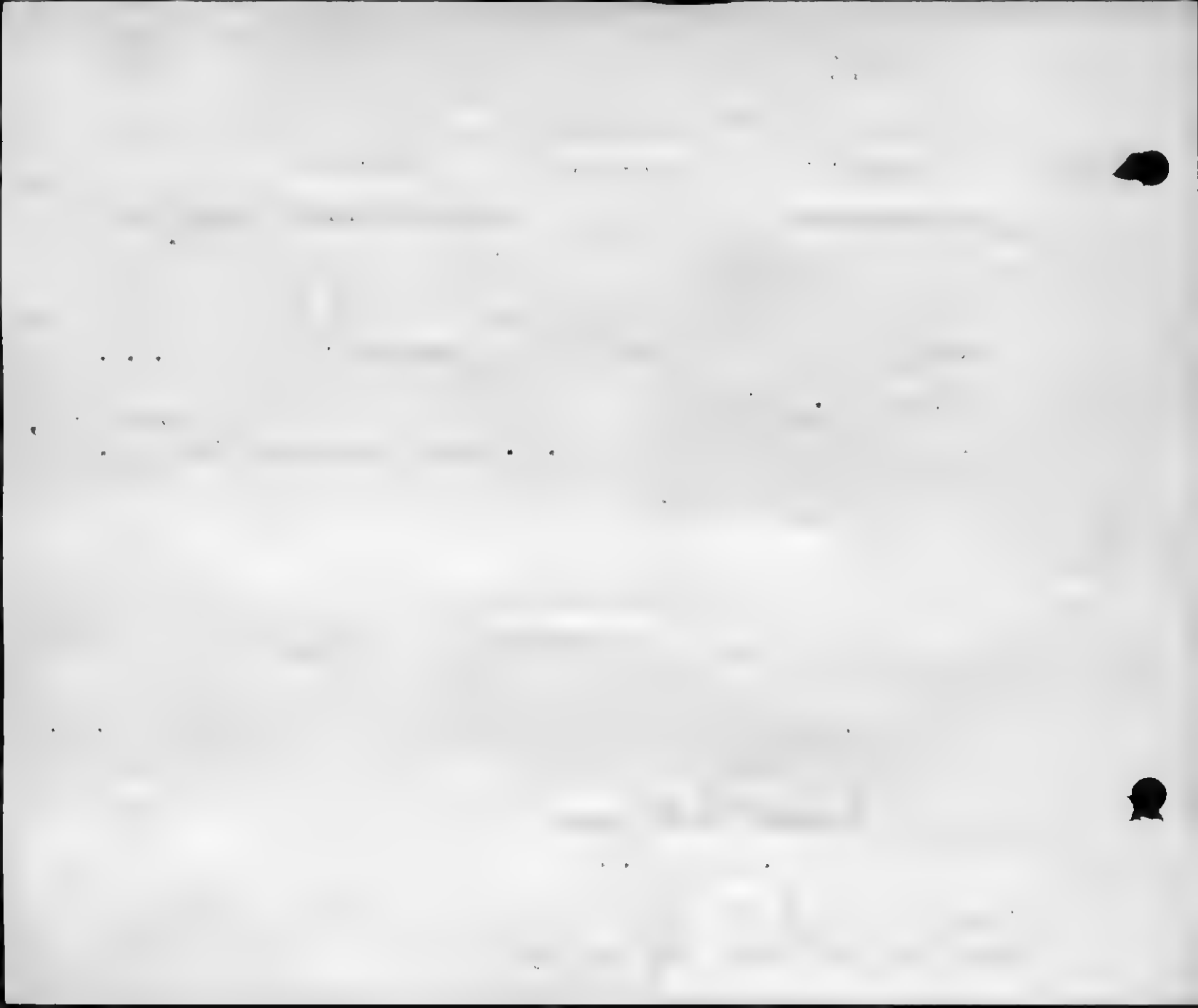
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00375 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00373

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if last but one residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 Welford Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MATTHEW		4. DATE OF DEATH January 20 1962	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Tippett	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond T. Tippett		14. MOTHER'S MAIDEN NAME Helen Almeda Morrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT R. B. Lowmes Germantown Pike Pa.		Address Lafayette Hill,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (b) third degree burns (c) Conflagration in home PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) third degree burns			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Conflagration in home	
20c. TIME OF INJURY Month, Day, Year Jan. 20 19 62		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> 115 Welford Road	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Baltimore Co. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 20, 1962	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-62	
22c. NAME OF CEMETERY OR CREMATORY St. Simon's Cemetery		22d. LOCATION (City, town, or country) (State) Philadelphia Pa.	
23. FUNERAL DIRECTOR Richard D. Lowmes		24a. REC'D BY REGISTRAR Jan 23 '62	
24b. REGISTRAR'S SIGNATURE Richard D. Lowmes		24c. REGISTRAR'S NAME Richard D. Lowmes	

MEDICAL CERTIFICATION



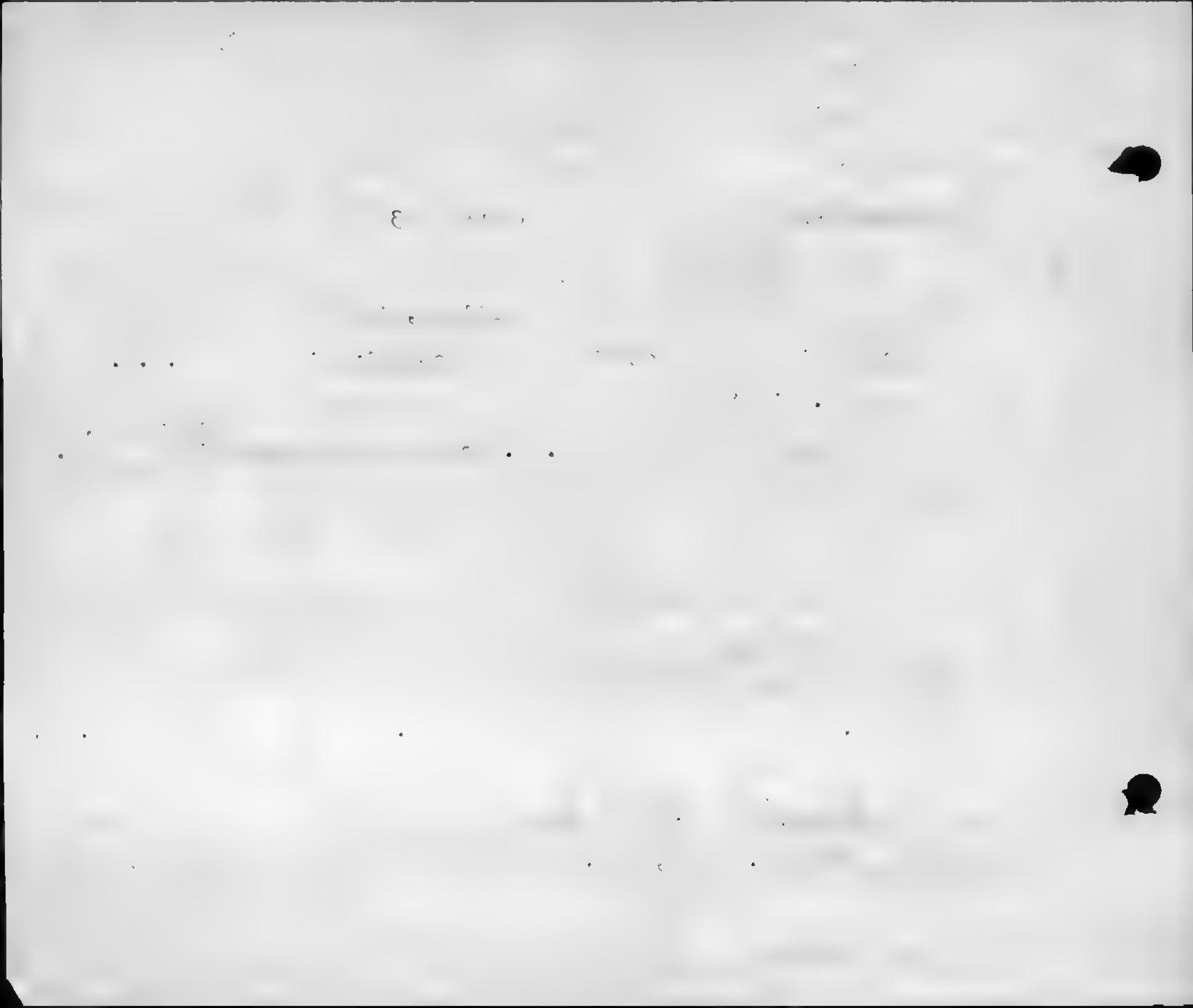
FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

<div> <div>1</div> <div>00376</div> <div>00374</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>Item 14-111m-5503 1/20/62 iwk</div> </div>											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b 2 yrs				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 113 Welford Road				d. STREET ADDRESS (same) 113 Welford Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Paul Tippet				4. DATE OF DEATH January 20 19 62							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1954		9. AGE (In years last birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Child				10b. KIND OF BUSINESS OR INDUSTRY School				11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond T. Tippet				14. MOTHER'S MAIDEN NAME Helen Almeda Morrison							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No NONE				16. SOCIAL SECURITY NO. NONE				17. INFORMANT R. D. Lownes Address Lafayette, Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to carbon monoxide poisoning DUE TO (b) _____ DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in home							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. Jan. 20 1962				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 113 Welford Rd.		20f. (City or town) Baltimore Co. Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED January 20, 1962			
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-24-62		22c. NAME OF CEMETERY OR CREMATORY St. Timothy's Cem.		22d. LOCATION (City, town, or country) Chiles, Penna.		(State)	
23. FUNERAL DIRECTOR Richard D. Lownes				ADDRESS Lafayette Hill, Pa.				24a. REC'D BY REGISTRAR JAN 23 '62		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

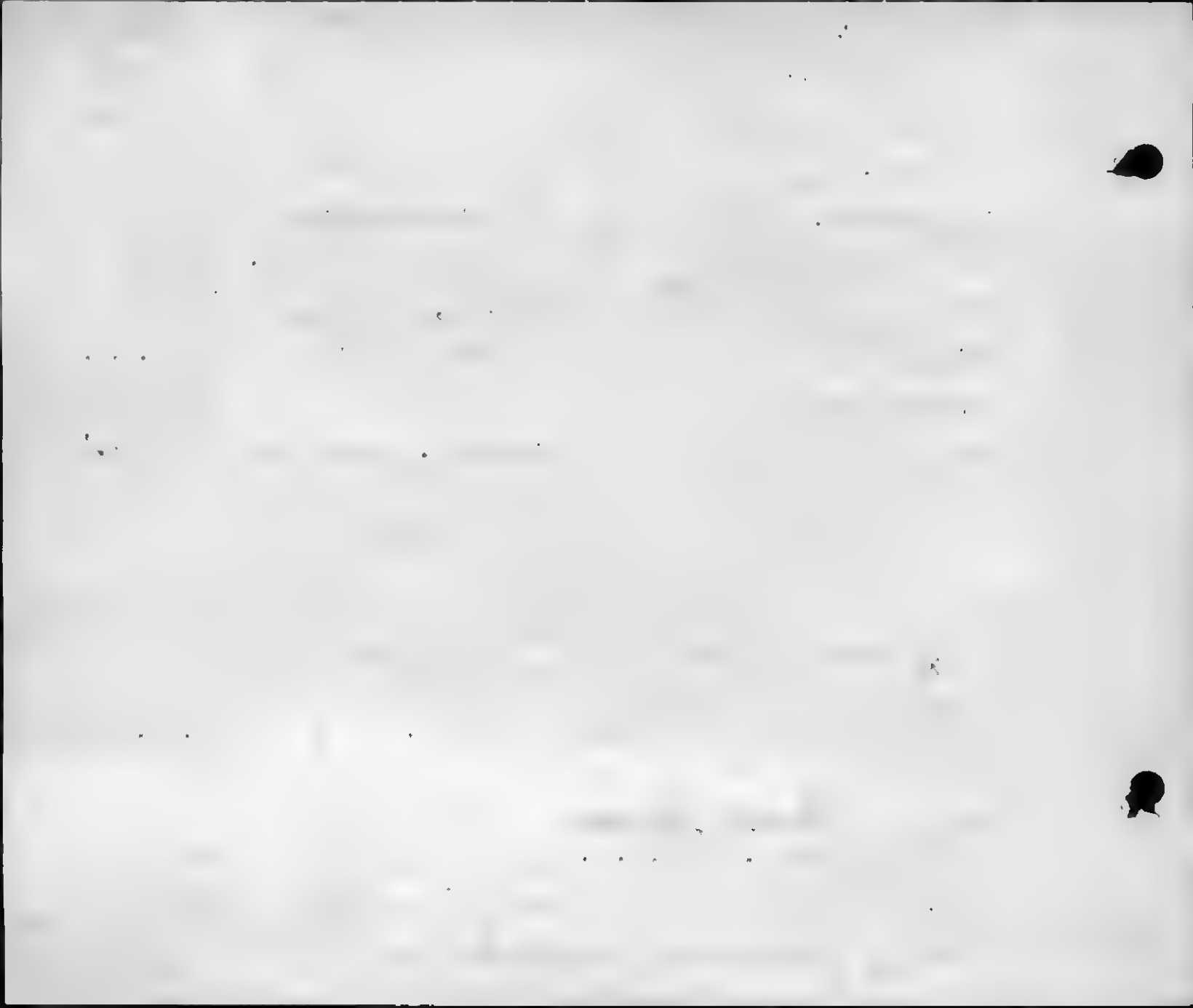
VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00377 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00375

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville c. LENGTH OF STAY IN 1b 2 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Welford Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville d. STREET ADDRESS 113 Welford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond T Tippet		4. DATE OF DEATH Month Jan. Day 20th Year 1962	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1927
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chain Belt		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	9. AGE (In years last birthday) 34 yrs IF UNDER 1 YEAR: Months 34 Days 34 Hours 34 Min.
13. FATHER'S NAME Raymond Tippitt		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Richard D. Lowmes	
17. INFORMANT Bancroft Lafayette, Pa		Address Germantown Pike	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO carbon monoxide poisoning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carbon monoxide poisoning DUE TO (c) carbon monoxide poisoning PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 2nd degree burns			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Conflagration in home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1/20 19 62 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 115 Welford Rd.	20f. (City or town) Balto. Co., Maryland (County) Balto. Co., Maryland (State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher		DATE SIGNED January 20, 1962	
EXAMINER'S NAME (Type) Russell S. Fisher, M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-24-62	
22c. NAME OF CEMETERY OR CREMATORY St. Timothy Cmn.		22d. LOCATION (City, town, or country) Philadelphia Pa.	
23. FUNERAL DIRECTOR Richard D. Lowmes		ADDRESS Lafayette Hill Pa.	
24a. REC'D BY REGISTRAR 23 '62		24b. REGISTRAR'S SIGNATURE Richard D. Lowmes	



MARYLAND STATE DEPARTMENT OF HEALTH

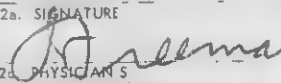

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00378

Item 2, b. Film 655 - 1/1/62 iwk

CERTIFICATE OF DEATH

00376

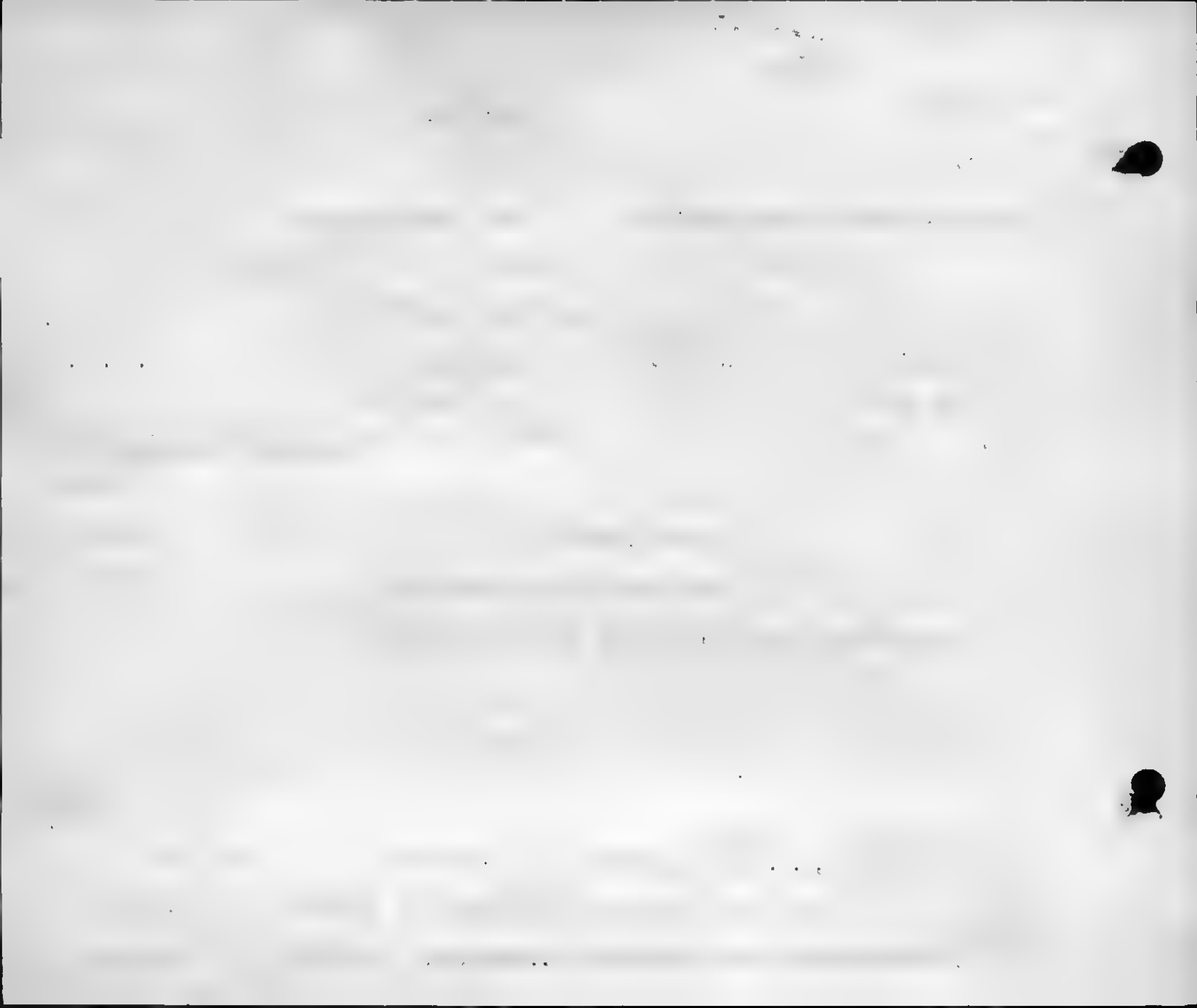
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 16 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5460 Lynview Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Last Month Day Year January 24 19 62 5. DATE OF BIRTH Last Month Day Year April 23, 1887 9. AGE (In years last birthday) 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman Automobile Radiators 13. FATHER'S NAME Jonas Markowitz		10b. KIND OF BUSINESS OR INDUSTRY Poland 11. BIRTHPLACE (County & State, or foreign country) U. S. - A. 12. CITIZEN OF WHAT COUNTRY? U. S. - A. 14. MOTHER'S MAIDEN NAME Dena Tanenbaum	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I 16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 446X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) CHRONIC NEPHRITIS DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME, SECONDARY TO ARTERIOSCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from January 8 1962 , to January 24 1962 , that (2) (we) last saw the deceased alive on Jan. 24 19 62 , and that death occurred at 2:07 P.M. from the causes and on the date stated above			
22a. SIGNATURE  22b. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D. Medical Service		22c. ADDRESS VAH, BALTO 18 MD FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Jan. 25, 1962		23c. NAME OF CEMETERY OR CREMATORY Anshe Emunah Congregation 23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Sons ADDRESS 6010 Reisterstown Rd. Balto. Md		25a. REC'D BY REGISTRAR JAN 29 '62 25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

100377

00379

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4414 Glenmore Ave.				e. STREET ADDRESS 4414 Glenmore Ave.			
3. NAME OF DECEASED (Type or print) First Otto Middle Urban Last Urban				4. DATE OF DEATH Month Januray Day 3 Year 19 62			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1888	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min 73	IF UNDER 24 HRS Months 73 Days 73 Hours 73 Min 73	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elevator operator				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Martin Urban			
14. MOTHER'S MAIDEN NAME Hattie Schreiber				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW 1			
16. SOCIAL SECURITY NO. 213-05-0510 A				INFORMANT Address John Urban 4414 Glenmore Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs (c) 5 yrs							INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.		
21. I certify that I attended the deceased from 1958 to 1962 that I last saw the deceased alive on 1-3 , 1962 , and that death occurred at 11:30 PM , from the causes and on the date stated above							
ACTUAL SIGNATURE Paul G. Mueller		ADDRESS (Street, city or town, state) 6411 BELAIR ROAD					
PHYSICIAN'S NAME (Type) PAUL G. MUELLER		DATE SIGNED BALTIMORE, #6 MID.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/8/62	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.			24a. REC'D BY REGISTRAR DATE JAN 10 '62		24b. REGISTRAR'S SIGNATURE Carroll S. Plummer		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00380

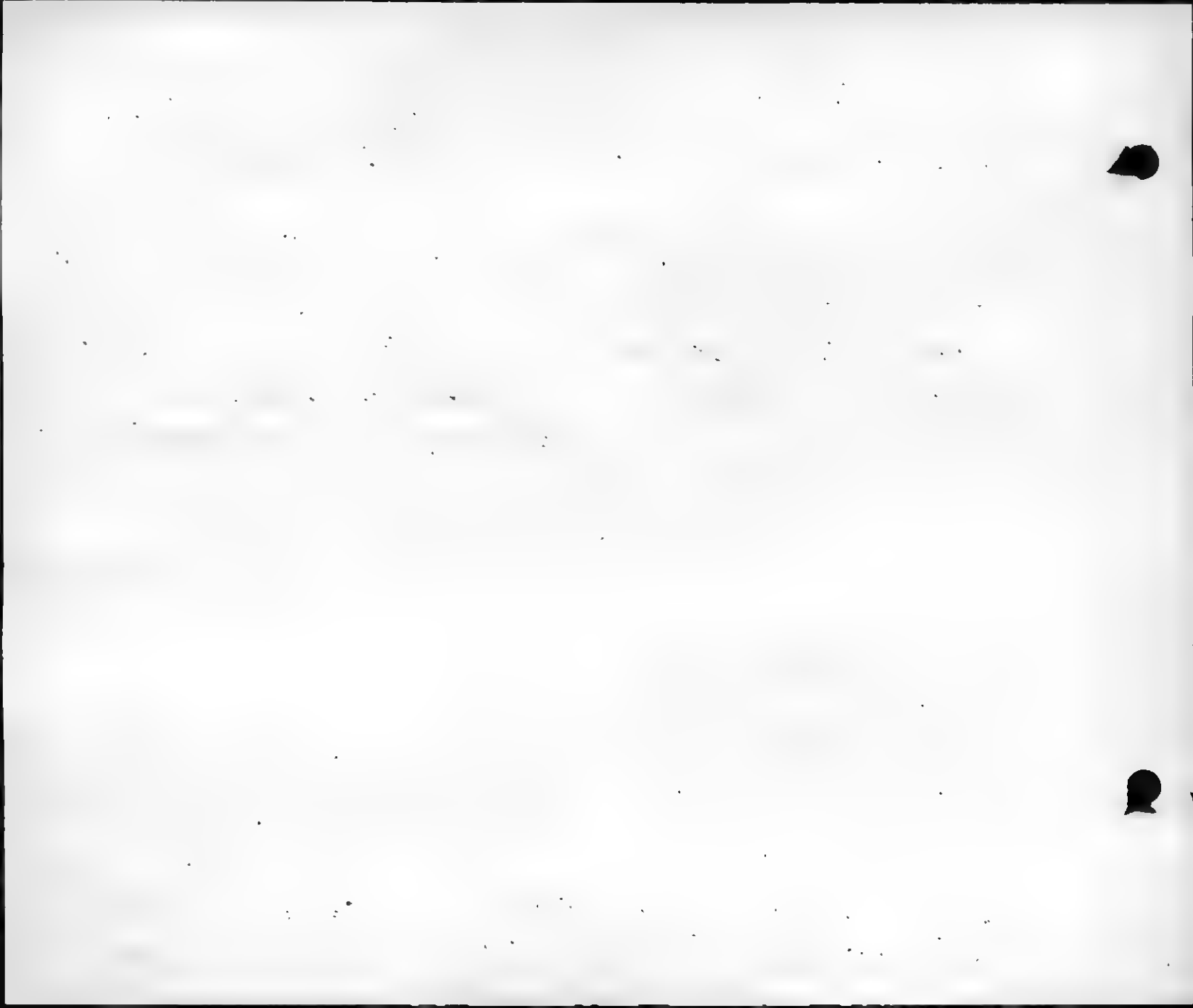
CERTIFICATE OF DEATH

Reg. Dist. No. 00378

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Randallstown</u>		c. LENGTH OF STAY IN 1b. <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Randallstown</u>	
		f. STREET ADDRESS <u>1500 Clinton Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN W. WADE</u>		4. DATE OF DEATH Jan. 8 1962	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1899</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert F. Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Clara E. Bone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. J. Perry Wade - Randallstown, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 199x DUE TO <u>Carcinomatosis (general)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/7/62</u> to <u>1/8/62</u> , that I last saw the deceased alive on <u>1/7/62</u> , and that death occurred at <u>12:00</u> M. from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Wm. E. Martin</u> M.D.		ADDRESS (Street, city or town, state) <u>Randallstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wm. E. Martin</u>		DATE SIGNED <u>RANDALLSTOWN, MD.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-11-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gruid Ridge</u>	22d. LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Lysanville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haight</u>

TO HOSPITAL OR FUNERAL HOME: This certificate must be completed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. IF FUNERAL DIRECTOR: Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in my event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00379

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

~~Phoenix~~ Jacksonville 13 1/2 years

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sweet Air Road Jacksonville, Md

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE Maryland

b. COUNTY Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

~~Phoenix~~ Jacksonville

d. STREET ADDRESS

Sweet Air Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

JOHN

ADOLPH

WALKER

5. SEX

Male

White

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

June 26, 1895

9. AGE (In years; If under 1 year, if under 24 hrs. last birthday)

66 6/5

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

S. Navy, Ret

10b. KIND OF BUSINESS OR INDUSTRY

Navy

Black and Decker Co, Massachusetts

11. BIRTHPLACE (State or foreign country)

Massachusetts

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Ellina Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes WW I & WW II

16. SOCIAL SECURITY NO.

219-28-7272

17. INFORMANT

Mrs. Marie Walker Sweet Air Rd Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

INTERVAL BETWEEN ONSET AND DEATH

Sudden

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Charles T. Howard M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S NAME (Type)

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Buried

22b. DATE THEREOF

1-23-1962

22c. NAME OF CEMETERY OR CREMATORY

Arlington National

22d. LOCATION (City, town, or country)

Arlington, Virginia

23. FUNERAL DIRECTOR

Brooks Funeral Service, Inc Towson Md

24a. REC'D BY REGISTRAR

JAN 23 '62

24b. REGISTRAR'S SIGNATURE

Charles L. Howe

VS. A15ME
5M 7/59

Film #3.5 - 1/1 - 1/2 in. 1/2 in.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many events, within 72 hours after death.

VR A15 (4)
15M 9/60

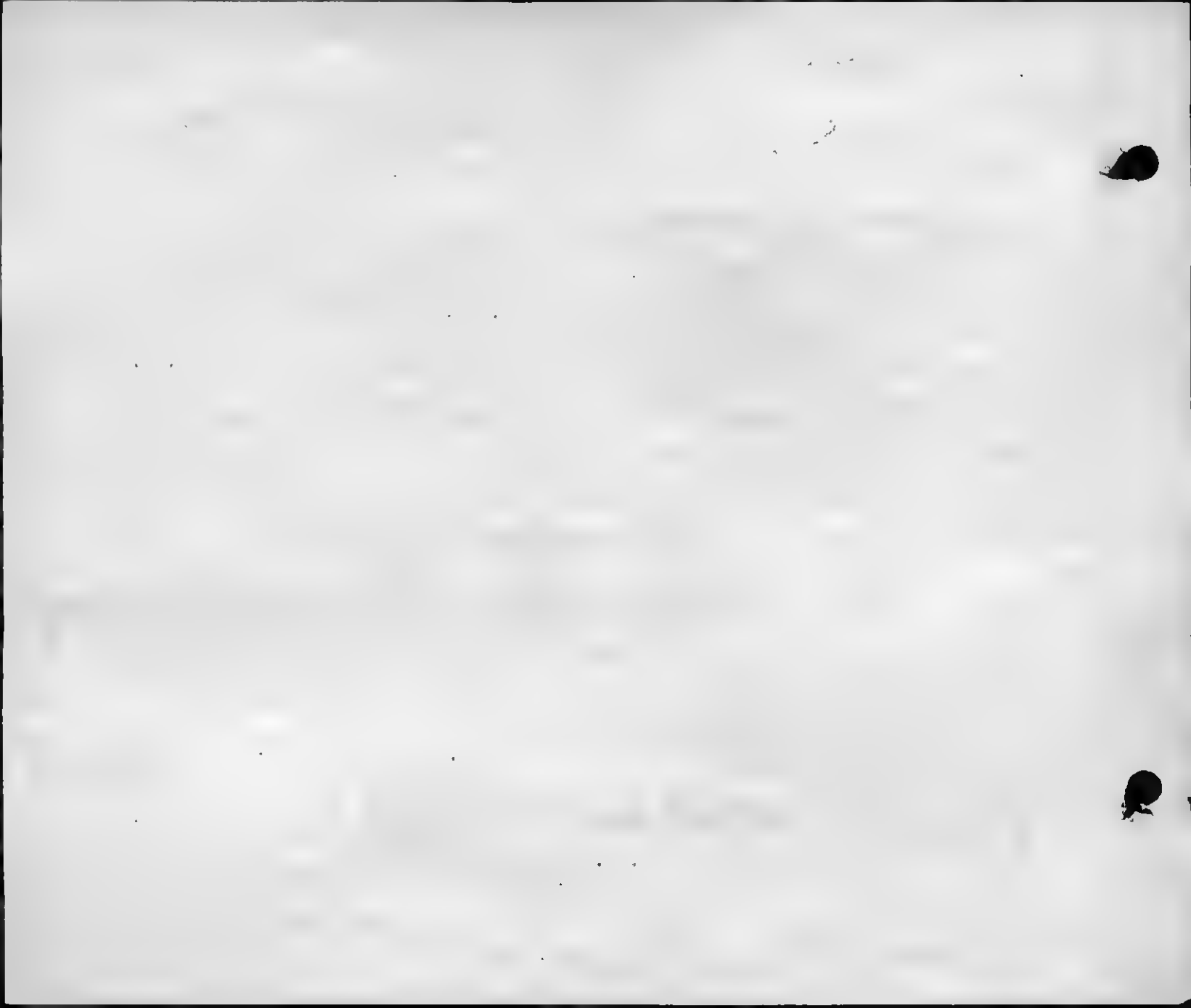
1

00382

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00380

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN b <u>5yr10mth17dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hollywood, Maryland</u> d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) <u>Pirley</u> First Middle Last 4. DATE OF DEATH <u>January 15 1962</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Dec. 12, 1876</u> WIDOWED <input checked="" type="checkbox"/> D. VORCED <input type="checkbox"/> 9. AGE (in years if under 1 year last birthday) <u>85</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>shipyard</u> 11. BIRTHPLACE (County & State or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Willet Weeks</u> 14. MOTHER'S MAIDEN NAME <u>Sadie New</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> 16. SOCIAL SECURITY NO <u>unknown</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Feb. 28, 1956</u> to <u>Jan. 15, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 15, 1962</u> and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Stella Wachsler</u> 22b. DATE SIGNED <u>1-15-62</u> 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-18-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gry Chapel</u> 23d. LOCATION (City, town or county) (State) <u>Leonardtown, Md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>William Clarke Mattingley</u> 25a. REC'D BY REGISTRAR <u>1962</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00383

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale				c. LENGTH OF STAY IN 1b 6 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5705 McCormick Ave.				d. STREET ADDRESS 5705 McCormick Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Susanna Middle Wendling Last Wendling				4. DATE OF DEATH Month Jan. Day 10, Year 19 62			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1883	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 78 Days 0 Hours 0 Min 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? Hungary	
13. FATHER'S NAME John Yost				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Margaret Moose Address 5714 McCormick Ave.			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma - Descending Colon. 153 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) -----							INTERVAL BETWEEN ONSET AND DEATH -----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General abdominal distention							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour ----- a. m. ----- p. m. ----- 19 62			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		
20f. (City or town) -----			20g. (County) -----			20h. (State) -----	
21. I certify that I attended the deceased from Aug 1 , 19 61 , to Jan 10 , 19 62 , that I last saw the deceased alive on January 8 , 19 62 , and that death occurred at 12 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Scheurich M.D.				ADDRESS (Street, city or town, state) 1337 S. Charles St. Balto 30. Md.			
PHYSICIAN'S NAME (Type) John A. Scheurich M.D.				DATE SIGNED Jan 15 1962			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/62		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Stevens				ADDRESS 1501 E. Fort Ave.		24a. REC'D BY REGISTRAR Jan 15 1962	
				24b. REGISTRAR'S SIGNATURE -----			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00384

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00382

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grey Manor c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2900 Page Drive		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grey Manor d. STREET ADDRESS 2900 Page Drive	
3. NAME OF DECEASED (Type or print) GENEVA First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home 13. FATHER'S NAME Chester Adkins		4. DATE OF DEATH January 10, 19 62 Month Day Year 8. DATE OF BIRTH March 20, 1918 Last birth day Months Days Hours M.m. 9. AGE (In years last birth day) 43 yrs. 11. BIRTHPLACE (State or foreign country) Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Don't know 17. INFORMANT John Wheatley Address 2900 Page Drive-22		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion + 20.1 } DUE TO Conditions, if any, which } (b) Coronary insuff gave rise to immediate cause } (a), stating the underlying } DUE TO cause last. } (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1-11-62			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/13/62 22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith 22d. LOCATION (City, town, or country) (State) Baltimore, Md.		23. FUNERAL DIRECTOR Ullrich Funeral Home Dundalk, Md. ADDRESS 24a. REC'D BY REGISTRAR 15 '62 DATE 24b. REGISTRAR'S SIGNATURE Thos E. Hanes	

MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH
10 hrs

8 yrs



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

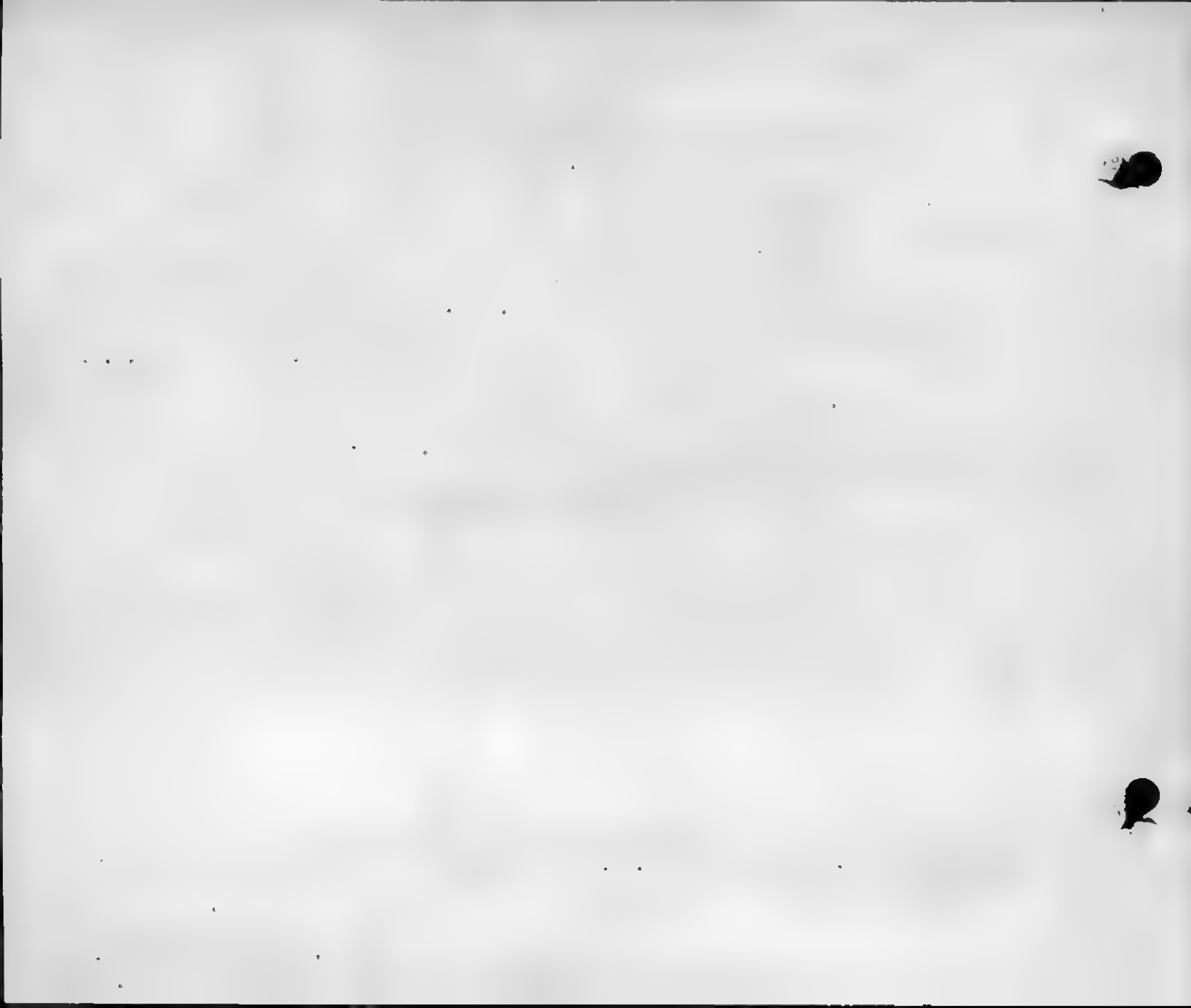
00385. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00383

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
c. LENGTH OF STAY IN lb 14 Mos.		d. STREET ADDRESS 8045 Park Haven Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8045 Park Haven Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOLLY ELIZABETH WHITTLE		4. DATE OF DEATH Month January Day 31 Year 1962	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1960
9. AGE (In years last birthday) 1 1/2 mos.		10. UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gorman E. Whittle		14. MOTHER'S MAIDEN NAME Carol Bond	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gorman E. Whittle - 8045 Park Haven		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis and pulmonary atelectasis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		January 31, 1962	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street city town or county)	
ACTUAL SIGNATURE R. Breitenecker, M.D.		NAME (Type) R. Breitenecker, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-3-62	
22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or country) (State) Trumps Mill Rd., Md.	
23. FUNERAL DIRECTOR		ADDRESS	
24a. REC'D BY REGISTRAR DATE JOHN J. DUDA		24b. REGISTRAR'S SIGNATURE 7922 Wise Av., Dundalk 22 Md.	

FEB 5 '62

Arthur S. Hays



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00386

00386

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (For out-of-county limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2824 Frederick Rd</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> d. STREET ADDRESS <u>2824 Frederick Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CURTIS F. Wilcox</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>27</u> Year <u>1962</u>		5. SEX <u>MALE</u>					
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 6, 1876</u>					
9. AGE (In years last birthday) <u>85</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH</u>			
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months Days	Hours Min.								
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Charles S Wilcox</u>		14. MOTHER'S MAIDEN NAME <u>Reese</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>							
17. INFORMANT <u>Irene Gilgash</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>U.S. C. V. D.</u> (b) <u>22.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hr</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Respiratory Distress</u>									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town)		20g. (County)		20h. (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1-6-62</u> to <u>1-27-62</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1-26-62</u> and that death occurred at <u>2:15</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>James S. Howard</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)					
22d. ADDRESS <u>Catonville</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN 30, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW Cem.</u>					
23d. LOCATION (City, town or county) <u>HOWARD Co.</u>		23e. (State) <u>MD.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>E. S. Malt + Son</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 1 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 1 of this certificate is to be retained by the hospital or attending physician. Page 2 of this certificate is to be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/80



TO HOSPITAL: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

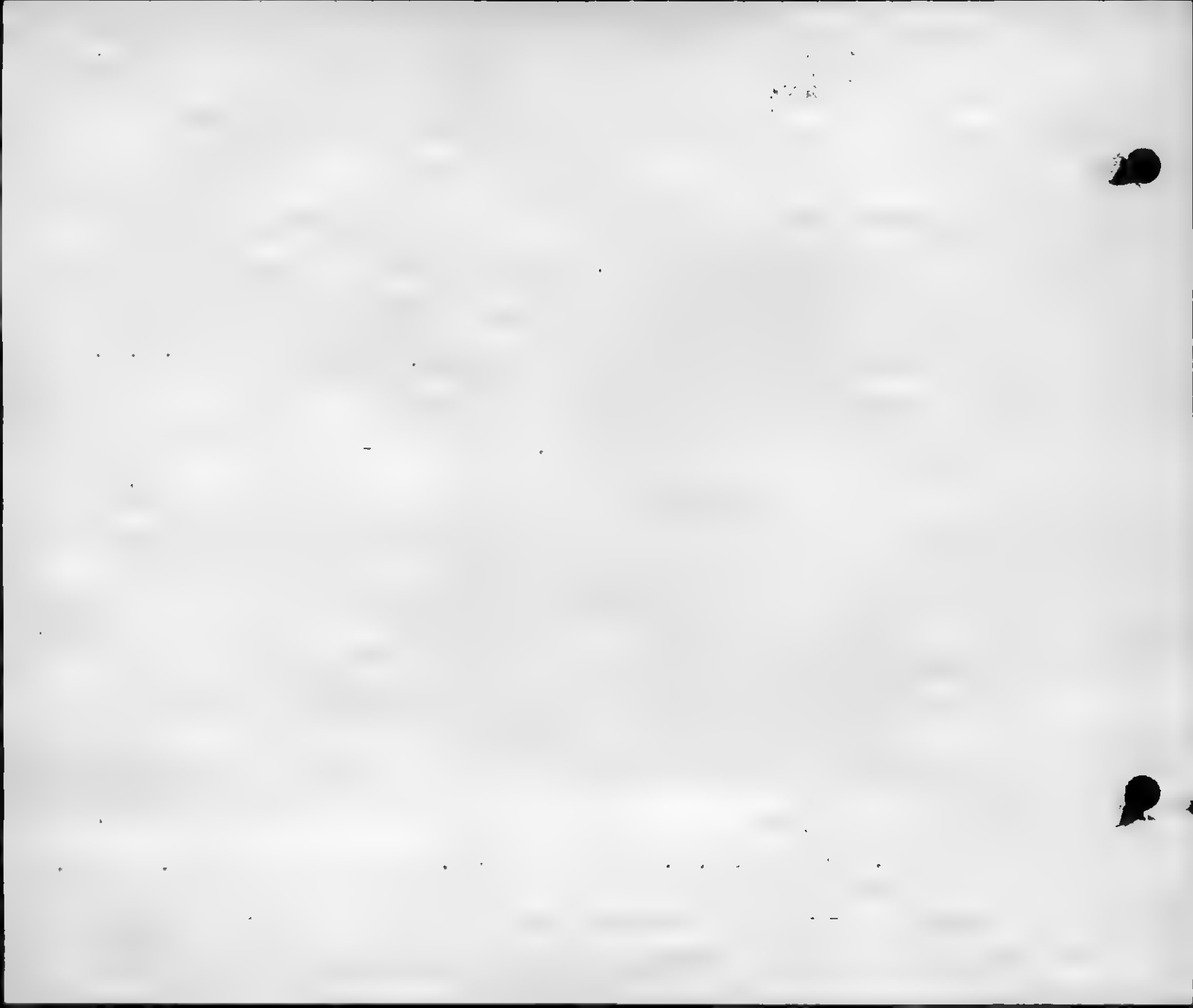
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00387

CERTIFICATE OF DEATH

00385

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>111 Burke Avenue</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>111 Burke Avenue</u>		e. 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sara A. Wilson</u> 4. DATE OF DEATH <u>January 30 1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 29, 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Belfast, Ireland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>William McMeekin</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. Mathew Wilson-111 Burke Avenue-Towson</u> Address <u>Towson</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> DUE TO (b) <u>None</u> Conditions, if any, which gave rise to immediate cause (c) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e): <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>		20c. TIME OF INJURY Month, Day, Year <u>None</u> 20d. INJURY OCCURRED <u>None</u> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u> 20f. (City or town) <u>None</u> (County) <u>None</u> (State) <u>None</u>		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1962</u> to <u>Jan 30, 1962</u> and that death occurred at <u>111 Burke Avenue</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Carl Myers</u> 22c. PHYSICIAN'S NAME (Type) <u>Carl Myers, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1401 E. Cold Spring Lane, Balto., Md.</u>		22b. DATE SIGNED <u>Jan 31, 1962</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u> ADDRESS <u>Baltimore 17, Maryland</u>		23d. LOCATION (City, town or county) <u>Baltimore</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Suber & Sons</u> 25a. REC'D BY REGISTRAR <u>FEB 1 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Carl Myers</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

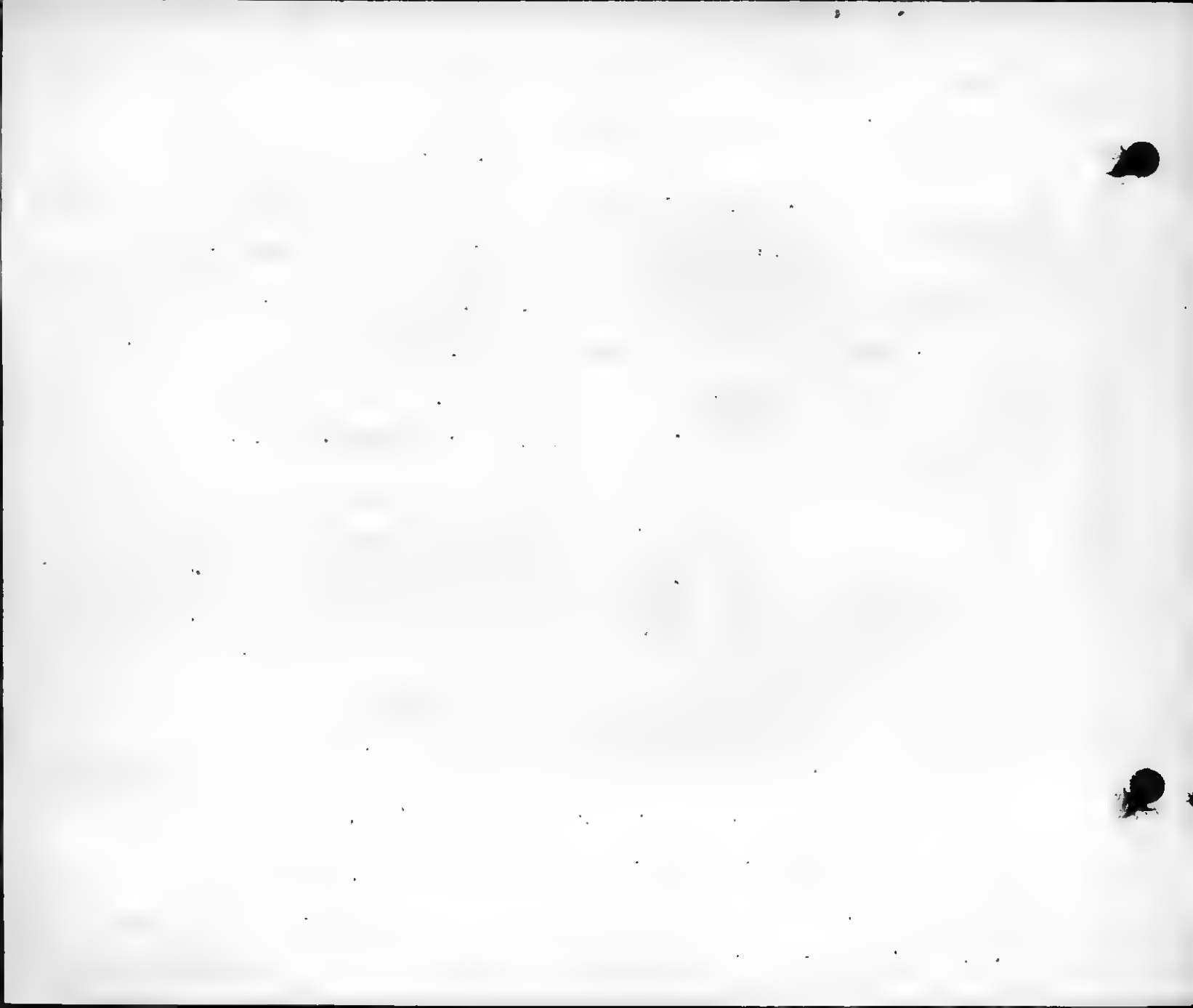
CERTIFICATE OF DEATH

Reg. Dist. No.

00388

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Professional House		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle WINAKUR Last WINAKUR		4. DATE OF DEATH Month January Day 25 Year 1962	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1885
9 AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Meyer		14. MOTHER'S MAIDEN NAME Mary ? Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no	
INFORMANT Mrs. Mary Ostrowsky-		Address 3212 Nerak Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Virus Pneumonia 4-1 DUE TO Hypertensive Cardiovascular Disease (b) Cerebral Thrombosis - with Left Hemiplegia DUE TO Chronic Lymphatic Leukemia - Discovered 11/23/59 (c) 10/1/59		INTERVAL BETWEEN ONSET AND DEATH About 2 weeks About 10 days 10/1/59	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Lymphatic Leukemia - Discovered 11/23/59		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/13/1954 to 1/25/1962 , that I last saw the deceased alive on 1/24/1962 , and that death occurred at 5:28 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 11 E. Chase St. DATE SIGNED 11 E. Chase Street			
ACTUAL SIGNATURE Theodore H. Morrison M.D.		PHYSICIAN'S NAME (Type) Theodore H. Morrison	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 26/62	
22c. NAME OF CEMETERY OR CREMATORY Shomra Shabos		22d. LOCATION (City, town, or county) (State) German Hill Rd Balto., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros Inc 6010 Reist Road		24a. REC'D BY REGISTRAR DATE JAN 29 '62	
24b. REGISTRAR'S SIGNATURE John S. Hunter			

TO HOSPITAL OR TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY BALTO. **MARYLAND**
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) CATONSVILLE
c. LENGTH OF STAY IN IL
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 501 ACADEMY RD

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD. b. COUNTY BALTO
c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) CATONSVILLE
d. STREET ADDRESS 501 ACADEMY RD. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last CHRISTIAN H. WOLFE
4. DATE OF DEATH Month Day Year JAN. 30 1962

5. SEX M **6. COLOR OR RACE** W **7. MARRIED** ☒ NEVER MARRIED ☐ B. DATE OF BIRTH AUG. 4 1901 **9. AGE** (in years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN TRANSIT CO **10b. KIND OF BUSINESS OR INDUSTRY** MD. **11. BIRTH-PLACE** (County & State, or foreign country) U.S.A. **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13. FATHER'S NAME HENRY WOLFE **14. MOTHER'S MAIDEN NAME** KATIE BLANK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **16. SOCIAL SECURITY NO** **17. INFORMANT** Mrs. C. H. Wolfe Address 501 Academy Rd.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary artery occlusion & myocardial infarction
Conditions, if any, which gave rise to immediate cause (b) Coronary artery atherosclerosis
(c) due to
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a).
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ **20b. DESCRIBE HOW INJURY OCCURRED** (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Feb. 14 1959 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

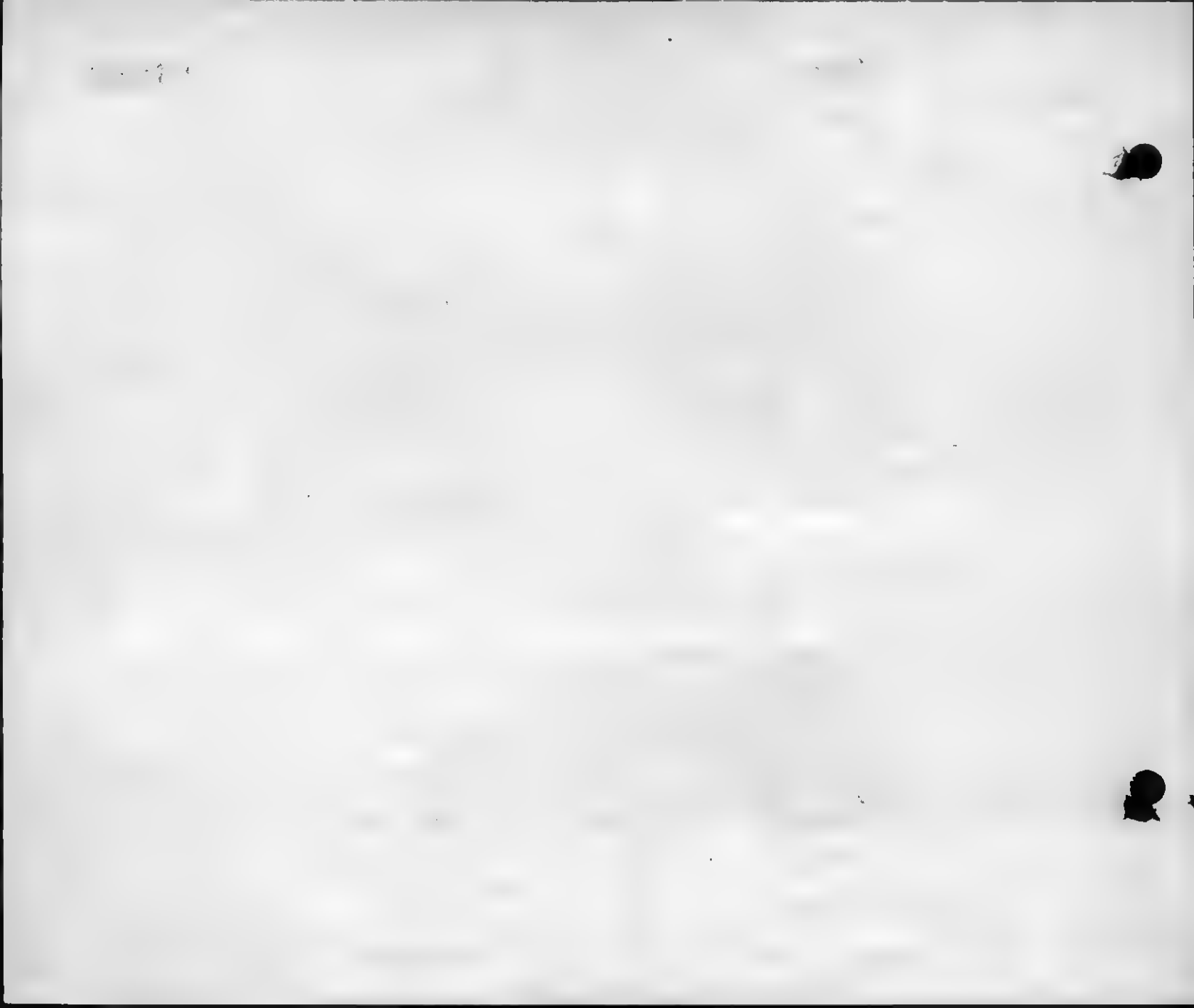
21. I certify that (I) (this hospital) attended the deceased from Feb. 14 1959 **to** Jan 30 1962 **that (I) (we) last saw the deceased alive on** Jan 30 1962 **and that death occurred at** 6:30 P.M. **from the causes and on the date stated above.**

22a. SIGNATURE Harry L. Knipp, M.D. **ATTENDING PHYS.** ☒ **MED. DIRECTOR** ☐ **STAFF PHYS.** ☐ **22b. DATE SIGNED** 1-31-62

22c. PHYSICIAN'S NAME (Type) HARRY L. KNIPP, M.D. **22d. ADDRESS** 4116 Edmondson Ave., Baltimore 29, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Buried **23b. DATE THEREOF** 2-2-62 **23c. NAME OF CEMETERY OR CREMATORY** CATHEDRAL CEM **23d. LOCATION (City, town or county)** BALTO. MD (State)

24. FUNERAL DIRECTOR'S SIGNATURE Forley Carranagh **ADDRESS** Funeral Home Catonsville **25a. REC'D BY REGISTRAR** FEB 8 '62 **25b. REGISTRAR'S SIGNATURE** C. H. Wolfe



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

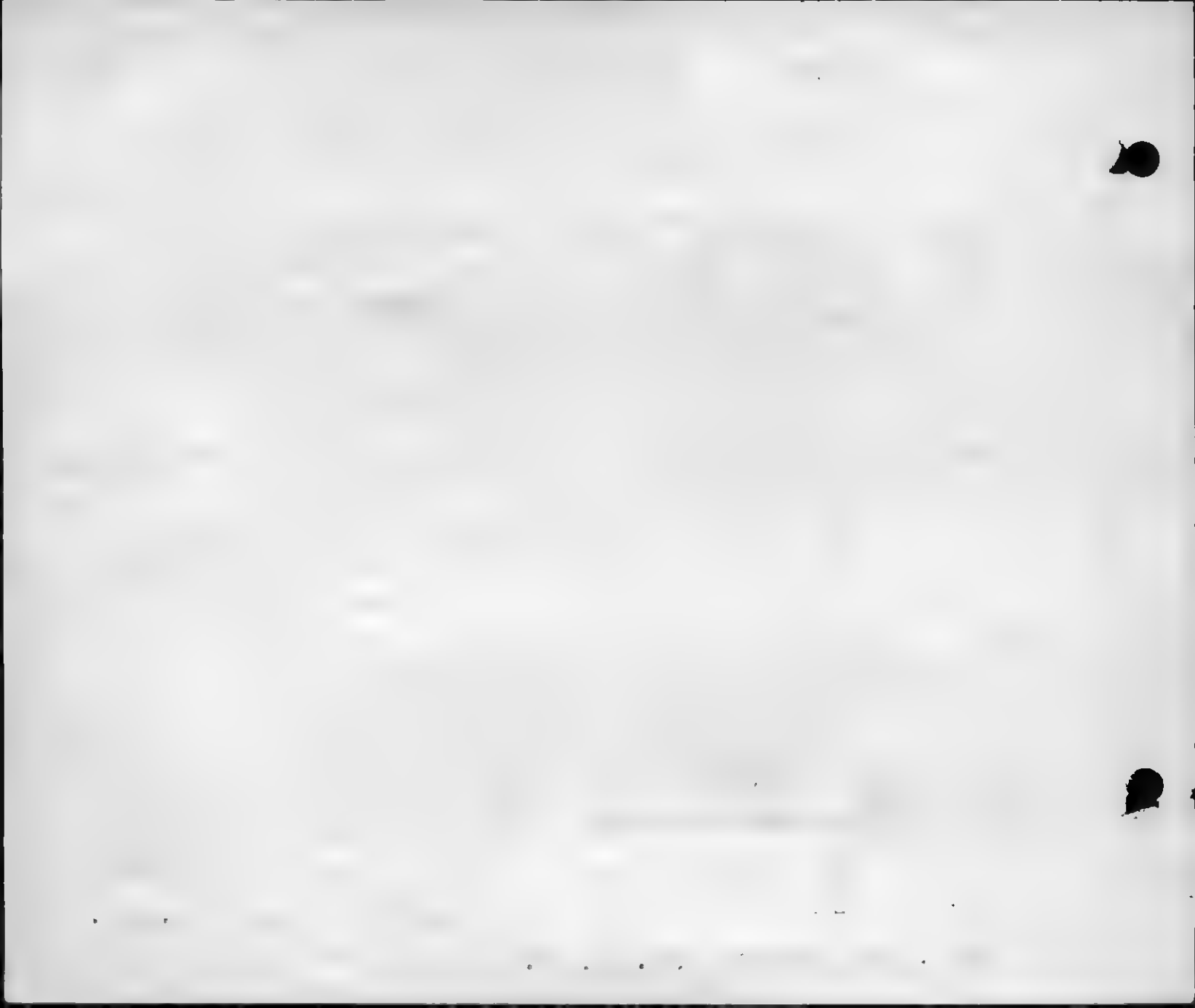
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00390

00387

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>4yr8mth27dys</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>1902 Augusta Avenue * Dundalk, Md.</u> d. STREET ADDRESS <u>1902 Augusta Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Stanley (Stanislaw) Wolosz</u>		4. DATE OF DEATH <u>January 2 1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 1893</u>	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. birth day) <u>68</u> rs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Mins.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wolosz</u>		14. MOTHER'S MAIDEN NAME <u>Mary Liptvics</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>218-10-8306</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u>			
492X DUE TO (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>			
DUE TO (c) <u>Arteriosclerotic heart disease - hypertensive</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m., p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from <u>April 5, 1957</u> , to <u>Jan. 2, 1962</u> , that (we) last saw the deceased alive on <u>Jan. 2 1962</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bruno Radauskas</u> M.D.		22b. DATE SIGNED <u>1-2-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bruno Radauskas, I. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSP. Catonsville 26, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-5-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Mary German Hill Rd. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN J. DUDA 7922 Wise Ave. 22, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 8 '62</u> 25b. REGISTRAR'S SIGNATURE <u>W. S. Kraus</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

00388

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davis Ave. Granite Md.</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Otto Yeager - Yeager</u>		4. DATE OF DEATH <u>Jan 1 - 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11 - 1898</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Md. P.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Yeager</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ernest A. Hipsley - Davis Ave Granite Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary failure, arteriosclerotic heart</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction, Hypertension,</u> DUE TO (c) <u>rt hemiplegia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>to</u> <u>1962</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1960</u> 19 to <u>1962</u> 19, that I last saw the deceased alive on <u>1 Jan 62</u> 19, and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>2431 E. Olney St</u> DATE SIGNED <u>2 Jan 62</u>	
PHYSICIAN'S NAME (Type) <u>Howard E. Hall</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 4 - 62</u>	<u>Greenmount Cem</u>	<u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Hall</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
ADDRESS <u>2431 E. Olney St</u>		DATE <u>JAN 5 '62</u>	<u>Arthur E. Hipsley</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The form is oriented horizontally on the page.

MASSACHUSETTS DEPARTMENT OF HEALTH



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5 to be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00392 CERTIFICATE OF DEATH 00389											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Towson					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Villa Maria - Notch Cliff						d. STREET ADDRESS Glenarm, Maryland					
3. NAME OF DECEASED (Type or print) Sister M. Hubertina (Zinkand)						4. DATE OF DEATH Month January Day 17 Year 19 62					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1874		9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months 5 Days da.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY United States	
13. FATHER'S NAME Peter Zinkand						14. MOTHER'S MAIDEN NAME Helen Bittrof					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give year or date of service)		17. INFORMANT Sr. M. Henrica Address Villa Maria Glenarm, Maryla					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Towson		20g. (County) Towson	
21. I certify that (I) (this hospital) attended the deceased from February, 1953 to January, 1962 , that (I) (we) last saw the deceased alive on Jan. 10, 1962 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles F. O'Donnell M.D.						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell			
22d. ADDRESS 7501 York Road Towson - Towson 4, Md.						22e. REC'D BY REGISTRAR DATE JAN 22 '62					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 1-20-62		23c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.				23d. LOCATION (City, town or county) (State) NOTCH CLIFF NR TOWSON, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeller						24a. ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kane			

